CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KF 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Record Identification

1. TITLE:	2. Form No. If available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐	☒	☐

REMARKS:

C P Force Records Management Officer 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

636001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

636001
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Highland Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janice M. Manning

3 (b) If veteran, name war –

3 (c) Social Security Account No. 212-01-9680

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles J. Manning

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) July 3, 1919

8. AGE: Years	Months	Days	If less than one day
26	5	29	hr. min.

9. Birthplace Philadelphia, Pa
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business Retired

FATHER
12. Name Horace Gross
13. Birthplace Philadelphia, Pa

MOTHER
14. Maiden Name Viola Lawrence
15. Birthplace Philadelphia, Pa

16 (a) Informant Charles J. Manning
(b) Address Ferndale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 46 (month) (day) (year)
(c) Cemetery or crematory Hily Cross
Location Ritchie Hwy., A. A. Co., Md.

18 (a) Funeral director Thomas W. Livingston
(b) Address Glen Burnie, Md.

(c) JAN 4 1946 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1946 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions Acute Congestive Cardiac Failure
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weedon M.D.
Medical Examiner.
Date signed 1-2-46

VS 151

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36002 — BALTIMORE CITY HEALTH DEPARTMENT — G36002

CERTIFICATE OF DEATH 93)

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 CHATEAU AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 36 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 CHATEAU AVE. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERTHA GRACE KYLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 3 1870

8. AGE: Years 75 | Months 11 | Days - | If less than one day ... hr. ... min.

9. Birthplace MARMOUTH, MAINE (Town, county, and state)

10. Usual Occupation LIBRARIAN

11. Industry or business

FATHER
12. Name AMOS M. KYLE
13. Birthplace MAINE

MOTHER
14. Maiden Name ELLEN A. BROWN
15. Birthplace MAINE

16 (a) Informant MABEL K. SMITH
(b) Address 518 CHATEAU

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 5 1946 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location BALTO. COUNTY

18 (a) Funeral director A. REILEY SLADE
(b) Address 4907 YORK RD.

19 (a) JAN 7 1946 (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1946, at 6 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to January 3 1946 and that I last saw her alive on 12/30 1945.

Immediate cause of death: Cardiac dilatation — Duration: 2 months

Due to: Hypertensive Cardio-Vascular Renal — Duration: 2 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hargrove

Address 214 Medical Arts Building Date signed 1/3/46 (M. D.)

Huntington Williams, M.D.

G36003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36003
Registered No.

1600a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Jane Peter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27-1945

8. AGE: Years	Months	Days	If less than one day
	1	8	hr. min.

9. Birthplace Balto Co.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carol Peter
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Mary V. Stuff
15. Birthplace Carroll Co.

16 (a) Informant Carol Peter
(b) Address Owings Mills

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7-46 (month) (day) (year)
(c) Cemetery or crematory Carrolls Chapel
Location Balto Co.

18 (a) Funeral director J. F. Slim Sons
(b) Address Reisterstown Md

19 (a) (Date rec'd by registrar) (b) Registrar

JAN - 4 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1946 at 6 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1945 to 1-4 1946, and that I last saw her alive on 1-4 1946.

Immediate cause of death	Duration
Intra - Cranial Hemorrhage	
Due to Bird injury -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George R. Callender M. D.
Address Univ. Hosp. Date signed 1-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ORIGIN RESERVED FOR BINDING

G36004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G36004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same as above

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town Perryville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Broad St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Cole

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Sarah Allen Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1864

8. AGE: Years	Months	Days	If less than one day
81	✓	18	hr. min.

9. Birthplace Perryville, Cecil, Md
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Whole Sale

FATHER
12. Name William H. Cole, Sr
13. Birthplace Newark, Dela.

MOTHER
14. Maiden Name Rebecca A. Emery
15. Birthplace Perryville, Md.

16 (a) Informant Caroline Cole
(b) Address Perryville, Md.

17 (a) Burial (b) Date thereof Jan 7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Principio
Location Principio Furnace, Md

18 (a) Funeral director Leo A. Catterson & Son
(b) Address Perryville, Md

JAN - 5 1946 (Date rec'd by Registrar) (Name) writing for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1946, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946, to Jan 4th 1946, and that I last saw him alive on Jan 4th 1946

Immediate cause of death	Duration
Circulatory collapse & cardiac failure	
Due to Cardiovascular Disease	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Gonzalez, M.D.
Address Maryland General Hospital Date signed 1/4/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the ca... the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDI...

G36003720 45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G36005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 613 Carrollton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clayton Hailey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1895

8. AGE: Years 50 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace N. Carolina (Town, county and state)

10. Usual Occupation Trader

11. Industry or business

FATHER
12. Name Octavius Hailey
13. Birthplace North Carolina

MOTHER
14. Maiden Name Arnetta Higgins
15. Birthplace North Carolina

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Phila. Pa.

18 (a) Funeral director Wm. Law. H. Holland
(b) Address 1631 Druid Hill Ave

JAN - 5 1946 Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION 46 05

20. DATE OF DEATH June 2, 1946, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1945 to June 2, 1945 and that I last saw him alive on June 2, 1945

Immediate cause of death Lobar Pneumonia — Duration 6 days
R.U.L., R.M.L.

Due to Pneumococcus Type I

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Pneumonia, Lobar, R.U.L., R.M.L.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clement J. Hopkins
Address Johns Hopkins Hosp. Date signed 1-3-46 M. D.

G36006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G36006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 E Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 2215 E Monument St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret C. Reiss

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frederick Reiss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1874

8. AGE: Years 71 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Louis Metz
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret Ott
15. Birthplace Germany

16 (a) Informant Mrs Wm Metzger
(b) Address 129 S East Ave

17 (a) Burial (b) Date thereof Jan 5
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location City

18 (a) Funeral director Lilliott Funeral Home
(b) Address 200 E Orleans St

19 JAN - 5 1946 (b) Huntington Williams, M.F.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1946, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Jan 1 1946, and that I last saw h[illegible] alive on Jan 1 1946.

Immediate cause of death	Duration
Broncho Pneumonia	8 day
Due to	
Due to La Grippe about	8 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E Finkelman M.D.
M. D.
Address 225 Meredith Rd Date signed Jan 1 46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3600 7

m JL - 97881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

G3600 7 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3131 Dillon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Jessie Sullivan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1870

8. AGE: Years 75 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace N. Y.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James
13. Birthplace Md.

MOTHER
14. Maiden Name Liza Edwards
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5th (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location City

18 (a) Funeral director Uzzel Funeral Home
(b) Address 2008 Orleans St

19 JAN - 5 1946 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan. 2 1946 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1945 to Jan. 2 1946 and that I last saw h alive on Jan. 2 1946.

Immediate cause of death: a Pneumonia
Due to: b Chronic prolonged Nephritis
Due to: c Comminuted, Complete Fracture of neck of left femur
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
None
of autopsy:

Duration: a ... b ... c ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? Accident
(b) Date of occurrence Dec. 15 1945 M
(c) Where did injury occur? Balto (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell to floor

23. Signature Eugene A. Hunting M. D.
Address B. C. H. Date signed

VS 150

To be approved by Medical Examiner.
Approved: Robert Lee Graham M.D. 1-3-46

G36008 G36008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1336

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Eight St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME DOROTHY LOUISE BARLOCK.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1942

8. AGE: Years	Months	Days	If less than one day
3 2	-	18	hr. min.

9. Birthplace BALTIMORE Md
(Town, county, and state)

10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Andrew S Barlock
13. Birthplace Braddock Penn

MOTHER
14. Maiden Name Thelma L. Olmstead
15. Birthplace Richmond Va

16 (a) Informant Mr Andrew S Barlock
(b) Address 4107 Eight St Brooklyn

17 (a) Burial (b) Date thereof Jan 5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Gor. Pulaski Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S Hanover St

DATE (Date rec'd by Registrar) 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 JAN 1946, at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945 to Jan 3 1946 and that I last saw h alive on Jan 3 1946

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Nephritis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W Markell M. D.
Address C of Jos Hosp Date signed 3 Jan 1946

G36009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1321a

Registered No. G36009

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered; where answer is "none," so state. Do not use ditto marks. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 N. Chapel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Chapel St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Reuschling

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Johanna Reuschling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1874

8. AGE: Years 72 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Housemans Restaurant

FATHER
12. Name Philip Reuschling
13. Birthplace Balt Md

MOTHER
14. Maiden Name Mary Hunke
15. Birthplace Germany

16 (a) Informant Mrs W. Reuschling
(b) Address 1512 N. Chapel St

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Jan 7-1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Baltimore Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 S Hanover St.

JAN - 5 1946 (Date rec'd by registrar) By Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1946 at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 to Jan 4 1946 and that I last saw h live on Jan 1 1946.

Immediate cause of death Respiratory failure

Due to Generalized Arteriosclerosis

Due to Arteriosclerotic Cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Shorofsky M. D.
Address 601 N. Monroe St Date signed 1/5/46

Shorofsky X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the

636010 BALTIMORE CITY HEALTH DEPARTMENT 636010

CERTIFICATE OF DEATH ✓ 106 c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 S. Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evan R. Ochs

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	3		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Herbert R. Ochs
13. Birthplace Pa

MOTHER
14. Maiden Name Nellie Ruckards
15. Birthplace Md

16. (a) Informant Nellie Ochs
(b) Address 920 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Frederick, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) JAN 5 1946 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan. 3 1946 at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Septicemia

Due to Gunshot fractures and lacerations

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Baker M.D. Medical Examiner
Date signed Jan. 3 1946

b36011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G36011 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Watson

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 45 | Months | Days | If less than one day hr. min

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Wash Alston

13. Birthplace N.C.

MOTHER 14. Maiden Name Margaret Alston

15. Birthplace N.C

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location.....

18 (a) Funeral director Elroy D. Wilson

(b) Address 1000 Bridgeley Ave

19 (a) (Date received by registrar) JAN 7 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1946 at 3:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 1 1946 and that I last saw her alive on Jan 1 1946

Immediate cause of death	Duration
? Cerebrovascular accident	
Due to	
Due to Pneumonia, lobar	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Pneumonia, lobar

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
(f) Signature William L. Dixon
Address Johns Hopkins Hospital Signed 1/2/46

X

G36012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2612 Allendale Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Allendale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Tonge Landauer

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John E Landauer

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26 1850

8. AGE: Years 95 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Washington
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John T Tonge
13. Birthplace Washington

MOTHER
14. Maiden Name Margaret E Butler
15. Birthplace Washington

16 (a) Informant Helen Louise Landauer
(b) Address 2612 Allendale Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 5 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry K Wolfe
(b) Address 4101 Edmondson Ave

19 (a) Jan 5 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 3 1946 and that I last saw h[illegible] alive on Jan 1 1945.

Immediate cause of death Congestive Heart Failure — Duration

Due to Arteriosclerotic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin G. Glasmann M.D.

Address 4037 Falls Rd. Date signed 1/4/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

636013 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1843 N. Regester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 31 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1843 N. Regester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS SCOTT LAKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Nellie Elizabeth
6 (c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) Feb 17, 1884

8. AGE: Years	Months	Days	If less than one day
61	10	17	hr. min.

9. Birthplace Red Bank, N. J. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business F. A. Levyne

FATHER
12. Name Edwin Lake
13. Birthplace New Jersey

MOTHER
14. Maiden Name Katherine D. Many
15. Birthplace New Jersey

16 (a) Informant Michael J. Lake
(b) Address 1637 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

JAN - 5 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1946, at 3-16 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23- 1945 to Jan-4 1946.
and that I last saw him alive on Jan- 1946

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	1 yr.
Other Conditions Arterio Sclerosis	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 1/4/46

G36014 G36014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline Sts.
(c) Hospital or institution: St. Joseph's Hosp. 9-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Chilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles B. Hall. (Charles Beverely Hall)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-07-2597

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age 1892 years

7. Birth date of deceased (mo., day, yr.) Mar 3, ~~1867~~

8. AGE: Years 53 ~~54~~ Months 10 Days 1 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Continental Can Co.

FATHER 12. Name James F. Hall

13. Birthplace Washington B.C.

MOTHER 14. Maiden Name Sarah Daugherty

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Elsie Foxwell- sister

(b) Address 1808 Chilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)

(c) Cemetery or crematory Louden Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) JAN - 5 1946 (Date rec'd by registrar) (b) Thurlington Williams M.D. (Registrar)

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/46 19 ; at 1:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1945 to 1/4 1946 and that I last saw him alive on 1/4 1946

Immediate cause of death	Duration
Toxemia	
Due to Gangrene of Legs.	
Due to Peripheral Arterial Disease, Arteriosclerotic	
Other Conditions Arteriosclerotic C.V.D. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. E. Everett M.D.

Address St. Joseph's Hosp Date signed 1/4/46

(over) X Everett

G36015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst.. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 955 N. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE APPS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert Apps
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 8, 1854

8. AGE: Years 81 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace: Baltimore County (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Martin
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Sarin Gooden
15. Birthplace: Baltimore County

16 (a) Informant: Miss Gertrude Apps
(b) Address: 955 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

JAN 5 1946 (Date rec'd by registrar) (Huntington Williams)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/46 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/46 to 1/2/46 and that I last saw h.e.r. alive on 1/2/46

Immediate cause of death: congestive failure — Duration:
Due to: arterio sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Leonard N. Smith M. D.
Address: Sinai Hospital Date signed 1-3-46

VS 150

G36016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G36016 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Alberta Fultz

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1900

8. AGE: Years 45 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Prince Geo. Co. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Stewart
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Jones
15. Birthplace Va

16 (a) Informant Roxey Fultz Garrison (Daug
(b) Address 415 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (b) Date rec'd by registrar JAN 5 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/46 19 at 6:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1945 to 1/2 1946 and that I last saw h[illegible] alive on 1/1 1946.

Immediate cause of death Edema
Myocarditis
Due to Chronic Nephritis
Due to
Other Conditions

Duration 1 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/4/46

G36017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36017 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 771 W. Lexington
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 771 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Turner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 231-10-1124

4. Sex M | 5. Color or race Cold | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1888

8. AGE: Years 58 57 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation L

11. Industry or business

FATHER 12. Name Geo Turner
13. Birthplace

MOTHER 14. Maiden Name Matilda —
15. Birthplace

16 (a) Informant Neatie Thomas
(b) Address 771 W. Lex St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Dayer
(b) Address 1142 Wolfe St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 5 1946

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1945 to Jan 2 1946, and that I last saw h— alive on Jan 1 1946.

	Duration
Immediate cause of death Acute Bronchitis	
Due to Pneumonia	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Huntington Williams M. D.
Address 1111 Eutaw Date signed 1/3/46

GB6018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 6360

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 S. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 S. Charles (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie R. Joyner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3 1865

8. AGE: Years	Months	Days	If less than one day
80	9	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Joyner
13. Birthplace Maryland.

MOTHER
14. Maiden Name Laura Dowling
15. Birthplace Maryland.

16 (a) Informant Mrs Phyllis M. Mitchell
(b) Address 217 E. Randall St.

17 (a) Burial (b) Date thereof 1/6/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location Frederick Ave

18 (a) Funeral director John F. Flynn Inc
(b) Address 716 Light St.

19 (a) (b) Huntington Williams M.D.
(Date received by Registrar)

JAN 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1941 to Jan. 2, 1946 and that I last saw h[illegible] alive on 1/2/46

Immediate cause of death Hypertension cardio vascular disease — Duration 4½ yrs.

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M.D.
Address 1226 Hanover St. Date signed 1/4/46

X

636019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

636019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE ON BACK. PRESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: So Balto Gen. Hosp. 2505
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Pascal St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lamartina

3 (b) If veteran, name war —

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-3-46

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Vincent J. Lamartina
13. Birthplace Balto.

MOTHER
14. Maiden Name Eleanor Lentz
15. Birthplace Balto.

16 (a) Informant Mr Vincent Lamartina
(b) Address 3919 Pascal St.

17 (a) Burial (b) Date thereof 1/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Glenburnie Md

18 (a) Funeral director John F Leary Son
(b) Address 74 E Fright St.

19 (a) (b)
(Filed by registrar)
JAN 5 1946
Huntington Williams Asst.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1946 at 9 46 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1946 to 1-3 1946 and that I last saw h[illegible] alive on 1-3 1946

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Ardinger M. D.
Address (21) Light St Date signed 1-3-46

X

G36020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G36020

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 Lauretta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Lauretta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca M. Wayson.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Wm. A. Wayson.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 15-1858.

8. AGE: Years	Months	Days	If less than one day
87.	0.	19.	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation House Work.
11. Industry or business at home.

FATHER
12. Name James Fowler.
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Md.

16 (a) Informant Harry E. Wayson.
(b) Address Washington D.C.

17 (a) Burial. (b) Date thereof Jan. 7-46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 5 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th; 1946, at 8- A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 1946.
and that I last saw deceased alive on Dec 29 1945.

Immediate cause of death: Arteriosclerotic Cardio Vasc. Disease — Duration

Due to

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. Corning M. D.
Address 400 N. Payson Date signed 1/4/46

G36021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

G36021 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 3E
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Pasternak

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-3971

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~ Michal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 1896

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name ? Domaredi
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Joseph Pasternak (Son)
(b) Address 1922 E. Pratt street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore md

18 (a) Funeral director George A. Weber
(b) Address 745 S. Grim st

19 (a) (b) (Date rec'd by registrar) Washington Williams M.D.

JAN 5 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4-1946 at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions Marked pulmonary edema.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stetarelie M.D. Medical Examiner.
Date signed 1-4-46

X

G36022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct and complete. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JOHN W. BRUCE

3 (b) If veteran, name war: World I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Gertrude
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 4, 1888
8. AGE: Years 57 | Months 5 | Days 28 | If less than one day hr. min.
9. Birthplace: Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation: Janitor
11. Industry or business

FATHER
12. Name: Beal A. Bruce
13. Birthplace: Randallstown, Md.

MOTHER
14. Maiden Name: Susan Smith
15. Birthplace: Baltimore Co. Md.

16 (a) Informant: Moses Bruce
(b) Address: Randallstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory: St. Thomas
Location: Baltimore Co. Md.

18 (a) Funeral director: Mrs. Chas. H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) JAN - 5 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1946 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William G. Helfrich, M.D.
Per Howard Schmeisser M.D.
Date signed 1-4-46

VS 151

G36063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V33a

Registered No. G36063

Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Dolphin st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorhurst Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1914

8. AGE: Years: 31 | Months: 8 | Days: 5 | If less than one day hr. min.

9. Birthplace: Chester Springs, Va (Town, county, and state)

10. Usual Occupation: Porter

11. Industry or business

FATHER
12. Name: Willie Mason
13. Birthplace: Chester Springs, Va

MOTHER
14. Maiden Name: Hallie Harris
15. Birthplace: Chester Springs, Va

16 (a) Informant: Mrs. Pearl Lee
(b) Address: 525 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1946 (month) (day) (year)
(c) Cemetery or crematory: Family lot
Location: South Boston, Va

18 (a) Funeral director: Mrs. Lucy H. Holland
(b) Address: 1631 Druid Hill Ave.

19 JAN - 5 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2nd 1946, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, influenzal.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Benedict Stavrakis M.D. (Medical Examiner.)
Date signed 1-2-46

G36034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G36034
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude Jason

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1909

8. AGE: Years 38 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert J. Jason
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Rachel Byas
15. Birthplace Camp Pamle, A. A. Co. Md

16 (a) Informant Robert Jason
(b) Address 1401 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1946 (month) (day) (year)

(c) Cemetery or crematory Western Star
Location Baltimore, Md.

18 (a) Funeral director Wm. George H. Holland
(b) Address 1691 Druid Hill Ave

19 (a) JAN - 5 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2- 1946, at 6 45 AM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Fourth degree burns
Due to Conflagration

Other Conditions Body is markedly charred.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 16/2
(a) Date of injury 1-2- at 4:27 A.M.
(b) Where did injury occur? 1510 Fairmount Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Conflagration

23. Signature Howard J. Cleveris M.D.
Medical Examiner.
Date signed 1-4-46

VS 151

G36035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36035
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 S. Castle St.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 S. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Jankiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16. (a) Informant Stephen Jankiewicz
(b) Address 127 S. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

Planting to William

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1946 at 11:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1945 to Jan. 4 1946 and that I last saw him alive on Jan 4 1946

	Duration
Immediate cause of death CEREBRAL HEMORRHAGE	1/1/46
Due to GENERALIZED ARTERIO-SCLEROSIS	??
Due to TERMINAL BRONCHO-PNEUMONIA	3 DAYS
Other Conditions ASTHMATIC BRONCHITIS	??

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Dunga, M. D.
Address 2007 E. Eastern Ave Date signed 1/14/46

G36036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered or the word "unknown" inserted. The correct age is especially important. Physicians: please write the causes of death clearly and describably.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 S. Mount St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S. Mount St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles E. Myles.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Teresa M. Myles
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 23-1875

8. AGE: Years 70 | Months 2 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business

FATHER
12. Name Charles E. Myles.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine F. Williams
15. Birthplace Balto. Md

16 (a) Informant Mrs. Teresa Myles.
(b) Address 205 S Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Geo. L. Berry Jr
(b) Address 1512 Hollins St

19 (a) (Date received by registrar) JAN 5 1946 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan 4 1946 at 5.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945 to Jan 4 1946 and that I last saw him alive on Dec 4 1946.

Immediate cause of death	Duration
Chronic myocarditis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Bergwell M. D.
Address 729 W Lombard St Date signed Jan 4 1946

G360,c7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G360,c7

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Annapolis Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robinson, Mrs. Wilbert Vida Anna Alverda Rankin Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John William Robinson
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 9 | 07 | 77

8. AGE: Years 68 | Months 3 | Days 7 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Utter
13. Birthplace Virginia

MOTHER
14. Maiden Name Julia Barrett
15. Birthplace Elkridge, Md.

16 (a) Informant Mrs. Ruth Lauba
(b) Address Randallstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Melville M.E. Church Cem
Location Elkridge, Md.

18 (a) Funeral director E. Willis Ramsburg
(b) Address 1003 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Register No.
JAN 5 1946
Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1946, at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1945, to 1/3 1946, and that I last saw h.E.B. alive on 1/3 1946.

	Duration
Immediate cause of death: Pulmonary Embolism	2 hrs
Due to: Thrombophlebitis Rt leg	10 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 12/21/45
Major findings of operation: Fractures Neck of Rt femur
of autopsy: Coronary sclerosis + Cardiac dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-12-45 at A. M
(c) Where did injury occur? 2605 Annapolis Rd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped + fell to floor

23. Signature [illegible], M.D.
Address Church Home Hospital Date signed M 1 D 3 1946

Approved by C.P. Huber, M.D.

G36038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 131a

Registered No. G36038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 Park Ave.
(c) Hospital or institution:
13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS KLEIN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Johanna Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1859

8. AGE: Years 86 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Hungary.
(Town, county, and state)
10. Usual Occupation Retired Shoe Merchant.
11. Industry or business

FATHER
12. Name Joseph Klein,
13. Birthplace Hungary.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Hungary.

16 (a) Informant Mr. Joseph Klein,
(b) Address Dumbarton, Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.6.46. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director David Sonnabend & Son
(b) Address 1902 Eutaw Place.

19 (a) Date received by Local Registrar JAN 5 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th. 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 3d 1946, and that I last saw him alive on Jan 3d 1946.

Immediate cause of death: Cardio renal Vascular disease
Myocarditis, Arteriosclerosis — Duration

Due to

Due to

Other Conditions Acute cardiac dilatation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. Kader M. D.
Address 2306 Eutaw Place. Date signed

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as far as possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 636029

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Marlborough Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts. (If rural, give location) Entaw Place W 2 to N St.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN A. LESEM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Isaac Lesem
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1849

8. AGE: Years	Months	Days	If less than one day
96	4	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Keyser,
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Gump,
15. Birthplace Germany.

16 (a) Informant Mr. Maurice Meyer,
(b) Address Marlborough Apts.

17 (a) Burial (b) Date thereof 1.6.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director David Sonnessin & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) Huntington Willis Bernard M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3rd. 1946, at PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1932 to Jan 3 1946 and that I last saw h[illegible] alive on Jan 3 1946.

Immediate cause of death	Duration
Uremia	2 weeks
Due to Senility arteriosclerosis	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Gold M. D.
Address Marlborough Apts. Date signed 1-3-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G36030 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell Likes

3 (b) If veteran, name war	3 (c) Social Security Account No.
	218-03-6060

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Likes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1901

8. AGE: Years	Months	Days	If less than one day
44	4	16	hr. min.

9. Birthplace Harrisonburg, Va. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Margaret Likes
(b) Address 1625 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1946 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1945 to 1-4 1946.
and that I last saw h[illegible] alive on 1-4 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic C. V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Lank
Address c/o H. Jos. Ley Date signed 1-7-46

X

G36031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

G36031 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2553 W. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2553 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Franklin Jones

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Mary P. Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1903

8. AGE: Years 42 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Loom Fixer

11. Industry or business Wm. Hooper & Sons

FATHER
12. Name Major H. Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Redmond
15. Birthplace Va.

16 (a) Informant Mrs. Russell Rhodes
(b) Address 2549 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)

(c) Cemetery or crematory
Location Savage, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan. 4 1945, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to Carbon Monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 4, 1945 M.
(b) Where did injury occur? 2553 W. North Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Asphyxiation by illuminating gas

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed 1-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 636032

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 10
(e) Length of stay in Baltimore (yrs., mos., or days) 93 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelia Ruth Allaire

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Henry Clay Allaire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1852

8. AGE: Years	Months	Days	If less than one day
93	5	28	hr. min.

9. Birthplace Baltimore Md USA (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Joseph Ruth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Adams
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St City

17 (a) Burial (Burial, cremation, or removal), (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18. (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JAN 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1946 at 5-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Jan 2- 1946, and that I last saw h[illegible] alive on Jan 2 1946.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	8 yrs
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 1/4/46

G36033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36033 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Hillman street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Aisquith street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH SULLIVAN

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 218-09-4770

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1908

8. AGE: Years 37 | Months 6 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Painter- Inspector

11. Industry or business Davidson Chemical Co.

FATHER
12. Name John Sullivan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary M. White
15. Birthplace Hanover, Penna.

16 (a) Informant Mr. John Sullivan
(b) Address 608 W. 36th street

17 (a) Burial (b) Date thereof Jan. 7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location

18 (a) Funeral director Chas J. Evans Sons Inc
(b) Address 11 E. W. M. Royde Ave

19 (a) (Registrar's signature) (b) Jan 8 1946 Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to Jan 4 1946.
and that I last saw h[illegible] alive on Jan 3 1946.

Immediate cause of death Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer
Address 506 S. North Ave Date signed 1-4-46

JAN 5 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6360 34 Jagelski

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 440

Registered No. 6360 34

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jagelski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218 09 4910

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter Jagelski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace: Biloxi Mississippi (town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name: Joseph Kazlowski
13. Birthplace: Poland

MOTHER
14. Maiden Name ?
15. Birthplace: Poland

16 (a) Informant: Walter Jagelski
(b) Address: 1501 Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 7/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Baltimore

18 (a) Funeral director: Fred W. Ozazewski
(b) Address: 1944 Eastend Ave

19. JAN 3 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3-46 19 at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1945 to 1-3 1946 and that I last saw her alive on 1-3-1946.

Immediate cause of death: Cachexia — Duration:

Due to: Hodgkin's Disease

Due to:

Other Conditions: Atelectasis of lung

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hodgkin's disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Bertha Rader M. D.

Address: Sinai Hosp. Date signed 1-3-46

VS 150

636035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

636035

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 416 Orchard St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-3

(e) Length of stay in Baltimore (yrs., mos., or days) 73yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 416 Orchard St
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER 12. Name George Simmons

13. Birthplace Md.

MOTHER 14. Maiden Name Rachel Johns

15. Birthplace Md

16 (a) Informant Charles L. Redmond

(b) Address 816 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.

Location

18 (a) Funeral director Adolphus Holstead

(b) Address 918 Edmondson Ave.

19 JAN - 5 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1946 at 5 47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1945 to 1-1- 1946, and that I last saw h alive on 12/30 1945

Immediate cause of death Chronic Cystic Pancreatitis
Renal Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thos Jackson M.D.

Address 1008 Calhoun St Date signed 1/3/46

VS 150

G36036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G36036 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 2223 Barclay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B DeFeo

3 (b) If veteran, name war

3 (c) Social Security Account No. 112-20-3846

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Rotanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 31 | Months 3 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace New York State (Town, county, and state)

10. Usual Occupation Street car operator, Balto Tr. Co

11. Industry or business

FATHER
12. Name Anthony DeFeo
13. Birthplace New York State

MOTHER
14. Maiden Name Livia Maria ?
15. Birthplace Italy

16 (a) Informant Mrs Rotanna DeFeo
(b) Address 2223 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre Cem
Location New Rochelle N.Y.

18 (a) Funeral director Joseph Farace Inc
(b) Address 2013 Hanover St Pkwy

19 (a) JAN - 5 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 January 1946, at 6:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Diphtheria, laryngeal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Hebert M.D. (Medical Examiner)
Date signed 4 January 46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36037

BALTIMORE CITY HEALTH DEPARTMENT

TN. 98201

CERTIFICATE OF DEATH

107

Registered No. G36037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- Days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Young Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hayward Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12th. 1945

8. AGE: Years	Months	Days	If less than one day
	8	19	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Reed Jr.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace Edenton N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Jan 5 /46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert V. Ellerby Dft
(b) Address 1129 N. Carolina St

JAN - 5 1946
(Date rec'd by registrar)

(b) Name and location of building for Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946 at 5.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 19 45 to Jan 2 19 46 and that I last saw him alive on Jan. 2nd 19 46

Immediate cause of death Acute cardiac failure — Duration

Due to Bilateral Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Richard C. Dorman M. D.
Address Balt. City Hosp. Date signed 1/3/45

VS 150

(over)

G36038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G36038

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 224
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Lashley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ernest Lashley
(b) Address 1734 E Eager St

17 (a) Removal (b) Date thereof Jan 5 /46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location La Crosse Va.

18 (a) Funeral director Mrs. Robert A. Elliott Dept
(b) Address 1129 N. Caroline St.

19 (a) (Date received by Registrar) (b) Registrar

JAN 7 1946 Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1945, at 2 30 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 1-2-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ... which ... information should be ...

Gen'l Sy any case. Released & Disp. —

BALTIMORE CITY HEALTH DEPARTMENT ✓ G36039

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlie Hopson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1902

8. AGE: Years	Months	Days	If less than one day
43	9	23	hr. min.

9. Birthplace Durham N. Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ben Hopson
13. Birthplace N. C.

MOTHER
14. Maiden Name Margaret Williamson
15. Birthplace N. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Jan 5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Durham N. Carolina
18 (a) Funeral director Mrs. Robert A. Elliott & Dept.
(b) Address 1129 N. Carolina St.
19 (a) JAN 5 1946 Washington Nationals Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION 4

20. DATE OF DEATH Jan - 3 - 1946 at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3- 1946 to 1-3 1946, and that I last saw him alive on 1-3 1946

Immediate cause of death Postero Inferior Myocardial Infarction — Duration 9 hrs.

Due to Occlusion of Rt. Coron. A.

Due to Arterio Sclerosis of Coronary A.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman D Stephens
Address Johns Hopkins Hosp. Date signed 1-5-46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fleming Rest Stafford Rd
(c) Hospital or institution: Eudenbourn Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Ramsey St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Stonesifer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3, 1941

8. AGE: Years	Months	Days	If less than one day
4	1	1	hr. min.

9. Birthplace Baltimore County Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles A. Stonesifer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Doris Smith
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 912 Ramsey

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Jan 7, 1946 (Month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location 3801 Frederick Ave.

18 (a) Funeral director John F. Conway & Son
(b) Address 901 W. Ellins St.

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

JAN 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946, at 9:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Jan 4 1946 and that I last saw him alive on Jan 4 1946

Immediate cause of death	Duration
Diphtheria	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan 4, 1946
Major findings of operation: Tracheotomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. E. Lee M.D.
Address Eudenbourn Date signed 1/5/46

6360:1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 6360:1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hospital
(c) Hospital or institution:
Wilkens & Caton Avenues
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 T
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Old Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH C. DALY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John J. Daly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75	-	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O'Brien
15. Birthplace Ireland

16 (a) Informant Rev. John J. Daly
(b) Address 3812 Old Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Mary M. Hadfield
(b) Address [illegible] 22nd St.

19 JAN - 5 1946 (Date rec'd by registrar) Huntingtown, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1946 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1946 to 1-4 1946 and that I last saw him alive on 1-4 1946.

Immediate cause of death	Duration
Heart failure	
Due to Coronary Thrombosis	
Due to Cerebro-sclerotic Cardio-Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cuthbert T. Hall Jr. M. D.
Address St. Agnes Hosp Date signed 1/4/46

G360:2 | BALTIMORE CITY HEALTH DEPARTMENT | G360:2

CERTIFICATE OF DEATH

94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED: Charles
(a) State: Md. (b) County: Somerset
(c) City or town: La Plata
(If outside city or town limits, write RURAL and give town)
(d) Street No.: (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Dr. Daniel Fisher

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ella
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1892

8. AGE: Years: 53 | Months: 2 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Pa. (Beaver Falls)
(Town, county, and state)

10. Usual Occupation: Physician

11. Industry or business:

FATHER
12. Name: Andrew J. Fisher
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Bridget R. O'Horman
15. Birthplace: Scotland

16 (a) Informant: Hospital Records
(b) Address:

17 (a) ~~Removal~~ Burial (Burial, cremation, or removal) (b) Date thereof: 1/7/46 (month) (day) (year)

(c) Cemetery or crematory:
Location: Swedesboro N. J.

18 (a) Funeral director: Wm. J. Tietken & Sons
(b) Address: Mo. & Penna Aves. Balto Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JAN 6 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/5 1946 at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2-46 19__ to 1-5-46 19__, and that I last saw him alive on 1-5-46 19__

Immediate cause of death: Resp. Failure — Duration:

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

25. Signature: Richard D. Kaufman M. D.
Address: Date signed 1-5-46

G360:3 | BALTIMORE CITY HEALTH DEPARTMENT ✓ | G360:3

CERTIFICATE OF DEATH 10

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harland Rd and Hessing Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State: West Va. (b) County
(c) City or town Fort Ashley
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Russell Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19 - 1927

8. AGE: Years	Months	Days	If less than one day
18	2	16	hr. min.

9. Birthplace Fort Ashley W. Va.
(Town, county, and state)
10. Usual Occupation Pinsetter in bowling alley
11. Industry or business

FATHER
12. Name Howard Lewis
13. Birthplace Romney, W. Va.

MOTHER
14. Maiden Name Naomi Ruth
15. Birthplace Romney, W. Va.

16 (a) Informant Patient
(b) Address 613 E. Baltimore St.

17 (a) Burial (b) Date thereof Jany 5, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fort Ashley
Location Fort Ashley West Va

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 19 as Eutaw Place

19 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5th, 1946, at 4:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26th, 1945, to Jan. 5th 1946, and that I last saw him alive on Jan. 5th, 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Diphtheritic myocarditis	
Due to Diphtheria – nasopharyngeal laryngeal, + tracheobronchial	
Other Conditions Pulmonary thrombosis + lung – etiology undetermined	

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy 12-28-45
Major findings of operation: Trachei-Bronchitis of Diphtheria
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Methuah Sprague M. D.
Address Sydenham Hosp. Date signed 1-5-46

Huntington Williams, M.D.

G360:4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G360:4

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1357 Sargent St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N/
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1357 Sargent St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ursula SAHKAUSKAS (SAHKAUSKAS)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1615

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Adella P. Sevicikas
(b) Address 4625 Wilkens Ave

17 (a) Burial (b) Date thereof 1-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kaminskas
(b) Address 602 Wetsh. Blvd.

(c) Huntington Williams M.D.

JAN 6 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1946, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 1/4 1946, and that I last saw h alive on 1/4 1946.

Immediate cause of death Arteriosclerotic cardio vascular disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.

Address 2030 Wilkens Date signed 1/4/46

1/4/46

G360:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

138

G360:5

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3421 Chestnut Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3421 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Ruth Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Divorced.

6 (b) Name of husband or wife Laurence Jones.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1897

8. AGE: Years 48 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Hair Dresser.

11. Industry or business Retired.

FATHER
12. Name William Scott.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Eliza J. Finzin
15. Birthplace Maryland.

16 (a) Informant Mrs. L. B. Bailey.
(b) Address 3421 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave.

19 6 1946 (Date filed by registrar) (Signature of registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1946, at 4 15/24 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1945 to Jan 4 1946 and that I last saw h[illegible] alive on Jan 3 1946.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Pulmonary Tuberculosis	2 yrs.
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature U. S. Smith M. D.
Address 3429 Chestnut Ave. Date signed Jan 4-46

VS 150

G360:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

Registered No. G360:6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3630 Hamwick Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3630 Hamwick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin H. Howard.

3 (b) If veteran, name war 1st W.W.

3 (c) Social Security Account No. 216-05-0336

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married.

6 (b) Name of husband or wife Grace P. Howard.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1897

8. AGE: Years	Months	Days	If less than one day
48.	-	28	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business Selfemployed Bus.

FATHER
12. Name Benjamin F. Howard.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary E. Corbin.
15. Birthplace Maryland.

16 (a) Informant Grace P. Howard.
(b) Address 3630 Hamwick Road.

17 (a) Burial (b) Date thereof Jan 6, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Popular
Location Balto Co. Md.

18 (a) Funeral director Ehrenwerth & Donovan.
(b) Address 3615-17 Chestnut Ave.

19 (a) JAN 6 1946
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1946, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Jan 3 1946, and that I last saw him alive on Jan 3 1946.

Immediate cause of death	Duration
Carcinoma of jaw	10 mos.
Due to Carcinoma of jaw	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. D. MacFaul Jr. M. D.
Address 840 W. 36th St Date signed 1/4/46

VS 150

G360-17

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G360-17 Registered No. 160a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 2.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Widman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1946

8. AGE: Years | Months | Days: 3 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Joseph Widman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Helen Olsen
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Judith J. Widman
(b) Address 1019 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd

18 (a) Funeral director Edmund McCaffrey & Son
(b) Address 924 E. Eager St

(c) JAN 6 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5-46 1946 11:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3/1946 to 1/5/1946 and that I last saw h[illegible] alive on 1/5/1946

Immediate cause of death Intra Cranial Hemorrhage — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Thos Scott M.D.

Address 1 W Lexington St Date signed 1/5/46 M. D.

G36048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G36048 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 EAST EAGER STREET.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 EAST EAGER STREET.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE B. HYLAND.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm A. Hyland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1873

8. AGE: Years 72 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife
11. Industry or business at Home

FATHER
12. Name Matthew McNamara
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Feeney
15. Birthplace Ireland

16 (a) Informant Miss Marie Hyland
(b) Address 922 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edward W. Conklin, Son
(b) Address 924 E. Eager St.

19 (a) Date received JAN 6 1946 (Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH JANUARY 4 1946 at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 2 1946 to JAN 4 1946 and that I last saw her alive on JAN 4 1946.

Immediate cause of death	Duration
APOPLEXY JANUARY 2 1946.	
Due to ARTERIOR SCLEROSIS	1944
Due to CHRONIC MYOCARDITIS	1944
Other Conditions HYPERTENSION.	

(Include pregnancy within three months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature Louis A. Claudius M. D.
Address 3013 ST PAUL ST Date signed JANUARY 4 1946.

X

G360:9 — BALTIMORE CITY HEALTH DEPARTMENT — G360:9 Registered No.

CERTIFICATE OF DEATH 186a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 President st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Mc Cabe

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 20 1895
8. AGE: Years 50 | Months 2 | Days 8 | If less than one day hr. min.
9. Birthplace Chicago Ill (Town, county, and state)
10. Usual Occupation Marines
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden Name
15. Birthplace
16. (a) Informant: Self
(b) Address
17. (a) Cremd (Burial, cremation, or removal) (b) Date thereof 1/6/46 (month) (day) (year)
(c) Cemetery or crematory Sunset
Location Sunset, Calif
18 (a) Funeral director Pallom Funeral Dir
(b) Address 1211 L St Sac Calif
19. (a) JAN-6 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28th 1945 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Fracture of skull. Contusion of brain, Intra-cranial Hemorrhage.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/28/45 12:30 P.M.
(b) Where did injury occur? 88. Stevenson Ave Balto 3 Md highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from ladder
23. Signature Benedict Whitarchie M.D. Medical Examiner.
Date signed 12-29-45

VS 151

G36050 G36050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2823 Baker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Tillson Rogers

3 (b) If veteran, name war: WW #1

3 (c) Social Security Account No. 216-03-6423

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marie Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1895

8. AGE: Years	Months	Days	If less than one day
50	7	8	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Cashier Retired
11. Industry or business Hardware

FATHER
12. Name Tillson Rogers
13. Birthplace Md

MOTHER
14. Maiden Name Lida McFaddon
15. Birthplace Md

16 (a) Informant Marie Rogers
(b) Address 2823 Baker St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Tillson Lobdell
(b) Address 1217 E Fayette St

19 (a) 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941 to Dec 1945 and that I last saw him alive on Dec 31 1945

Immediate cause of death
Coronary Heart Disease — ? Duration
Coronary Thrombosis — 5 years Mo
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Nelson Carey M. D.
Address 1014 E Read St Date signed 1-10-46

VS 150 Thurlington Williamson, Md

G36051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36051 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2245 East Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2245 East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Elizabeth Lusby

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3. 1880

8. AGE: Years	Months	Days	If less than one day
65	10	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Lusby
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jennie Cunningham
15. Birthplace Md

16 (a) Informant Florence Lusby
(b) Address 2245 East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Thomas Ford Sr
(b) Address 1217 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) Livingston Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946 at 1.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1943 to Jan 4 1946 and that I last saw h Sr alive on Jan 3 1946

Immediate cause of death	Duration
Coronary Thrombosis	3 days
General Arteriosclerosis	
Due to Hypertension	
cum Myocardial	
Due to infarction + degeneration	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry C. Hyde M. D.
Address 1100 E Monument Ave Date signed 1/4/46

Reg 1946

Harry C. Hyde X

G36052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1469

G36052 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 W. Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alice K. Taylor

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6. (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband: Richard E. Taylor
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 13th 1869

8. AGE: Years: 76 | Months: 0 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Port Hope Can.
(Town, county, and state)

10. Usual Occupation: Housework
11. Industry or business: at Home

FATHER
12. Name: John Langford
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Emma Jones
15. Birthplace: England

16 (a) Informant: Harold F. Taylor
(b) Address: 313 W. Lorraine Ave

17 (a) Burial (b) Date thereof 1/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul st

19 (a) JAN 9 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-4- 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1946 to 1-4 1946, and that I last saw h e alive on 1-4 1946.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Acute Pulmonitis?	
Due to: Neoplasm of Lung or Pulmonary	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Wm H. Frank M.D.
Address 1 E. Mt. Jas. Hosp. Date signed 1-4-46

VS 150

G360-53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G360-53 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 443 Yale Ave
(c) Hospital or institution: 0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 443 Yale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Beyer

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-3543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Anna Beyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23rd 187-

8. AGE: Years	Months	Days	If less than one day
72	5	11	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Male Nurse
11. Industry or business Edgewood Arsenal

FATHER 12. Name Otto Beyer
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mary A. Beyer
(b) Address 443 Yale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) (b) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 1/4 1946, and that I last saw h[illegible] alive on 1/2 1946.

Immediate cause of death Cardiac Infarction — Duration 2 hrs
Due to Hypertension
Due to
Other Conditions Hemiplegia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James M. Katzenberger M.D.
Address Fort McHenry Guard Date signed 1/5/46

VS 150

James M. Katzenberger

G36054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G36054
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 N. Madeira St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Madeira St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Hudak

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Michael Hudak
6 (c) If alive, give age. years
7. Birth date of deceased (mo., day, yr.) Feb. 11, 1861
8. AGE: Years 84 | Months 10 | Days 23 | If less than one day hr. min.
9. Birthplace: Slovakia (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business

FATHER
12. Name: Joseph Velenovsky
13. Birthplace: Slovakia

MOTHER
14. Maiden Name: Ant Krown
15. Birthplace: Slovakia

16 (a) Informant: Anna Hurtan
(b) Address: 404 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto - Md
18 (a) Funeral director: Frank Enoch & Son
(b) Address: 900 N. Chester St
19 (a) Filed by registrar Jan 9 1946 Wilmington, Del. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946 at 1:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 19 45 to Jan 9 46, and that I last saw h alive on Jan 2 19 46

Immediate cause of death
Due to Hypertension
Due to Cardiac Decay
Other Conditions Coronary

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 y

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: [illegible] M.D.
Address: [illegible] Date signed 1-9-46

VS 150

G36055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4109 Penhurst Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Penhurst Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Jane Elliott

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Talbott L. Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19-1867

8. AGE: Years 78 | Months 10 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joshua Hurst
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Keys
15. Birthplace Maryland

16 (a) Informant Mrs. Marie E. Gardiner
(b) Address 3719 Sequoia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7-1946 (month) (day) (year)
(c) Cemetery or crematory New Market
Location Maryland Line Balto. Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

Date received JAN 6 1946 (b) Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4- 1946, at 1:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/45 19 to 1/4 19 46
and that I last saw h er alive on 1/3 19 46
Immediate cause of death Heart Failure — Duration 1 day
Due to Auricular Fibrillation — 2 wks
Due to Arterio Sclerosis — 10 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 19 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Boulton
Address 3304 Gunston Road Date signed 1/5/46 M. D.

G36056 — BALTIMORE CITY HEALTH DEPARTMENT — G36056 Registered No.

CERTIFICATE OF DEATH 131a

Please write the causes of death clearly and legibly. Physicians: please write in ages in months or days if under one year. Do not forget age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Hill St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Hill St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Zaleski

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Felix Zaleski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1897

8. AGE: Years	Months	Days	If less than one day
48	6	17	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER — 12. Name unknown
13. Birthplace unknown

MOTHER — 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Helen Lenyon LANSNER
(b) Address 1210 Towson

17 (a) (Burial, cremation, or removal) (b) Date thereof 1/6/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.
18 (a) Funeral director Chas. F. Dull
(b) Address 1501 E. Fort Ave.
19 (a) 1946 (Date rec'd by registrar) (b) Huntington Nilliams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1946 at 1201 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to June 3 1946 and that I last saw h.er alive on June 2 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	3d
Bronchial Pneumonia	2d.
Due to Chronic Nephritis	3d
Hypertension	3d
Due to Gen Disturbed Metabolism	3d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature P F A Stevens M. D.
Address 2478 Harford Rd. Date signed

G36057 G36057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 E. Eager Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Polly E. Hopewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Wm. D. Hopewell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1900

8. AGE: Years 45 Months - Days 10 If less than one day hr. min.

9. Birthplace Jarvisburg, N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Hall
13. Birthplace Jarvisburg, N. C.

MOTHER
14. Maiden Name ?
15. Birthplace Jarvisburg, N. C

16 (a) Informant Rev. Wm. D. Hopewell
(b) Address 1905 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore County, Md.

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Jan 1946 (Huntington Williams M.D.)
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1946 at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1945 to Jan. 3 1946 and that I last saw her alive on Jan. 3 1946.

Immediate cause of death (Enter only one cause per line for (a), (b), and (c).)
(a) Coronary - Occlusion
(b)
(c)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Powell M. D.
Address 1422 E. Chase Date signed 1-5-46

VS 150

G36058 | BALTIMORE CITY HEALTH DEPARTMENT | G36058

CERTIFICATE OF DEATH

1927 | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1921 Clifton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 1921 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Ostrow

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Leo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Isaac Ehrenreich
13. Birthplace not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Jean Ostrow
(b) Address 1921 Clifton Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 1-6-46 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phila. Rd. & Prospect Park

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) JAN 6 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 03 January 1946, at 1145 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Hypertension & Cardio Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. A. Schlaich M.D. Medical Examiner.
Date signed 4 Jan 46

X

G36059 | BALTIMORE CITY HEALTH DEPARTMENT | G36059

CERTIFICATE OF DEATH 97

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Trupp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name Phelep
13. Birthplace Russia

MOTHER 14. Maiden Name Goldie
15. Birthplace Russia

16 (a) Informant Irvin J. Trupp
(b) Address 2058 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-46 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew Cem
Location Belair Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 434 E Balto St

(c) JAN 6 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1946, at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8:30 A.M. Jany 5 1946 to 3:30 A.M. Jany 5 1946 and that I last saw him alive on Jany 5 1946.

Immediate cause of death Acute Pulmonary Edema — Duration afterhours

Due to Chr Hypertension — Duration at least 20 yrs

Due to Chr Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J W Keaton M.D.
Address 1938 Linden Ave Date signed 1/5/46
Howard J. Worden, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36060 BALTIMORE CITY HEALTH DEPARTMENT G36060

CERTIFICATE OF DEATH 940

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 S. Macon Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S. Macon Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Eiler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alice Eiler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68				

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Eiler
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant
(b) Address 612 S. Macon Street

17 (a) Burial (b) Date thereof 1-8-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Avenue

18 (a) Funeral director Frederick D. Malley, Inc.
(b) Address 3015 E. Monument Street

19 (a) (b)
(Date rec'd by registrar) Registrar

1-8-1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4th 1946 at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Jan 4 1946, and that I last saw him alive on Jan 3 1946

Immediate cause of death Coronary Thrombosis — Duration 6 years

Due to Arteriosclerosis Hypertension

Due to

Other Conditions Pulmonary oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Jacobs M.D.
Address 617 North Ave Rd Date signed 1/5/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

922

G36061 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7325 Potomac St
504 N Caroline (Ent)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Thomas

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Nov 28 1879

8. AGE: Years 66 | Months 1 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Contimental Can

11. Industry or business Ret

FATHER
12. Name Wm L Thomas
13. Birthplace Balto

MOTHER
14. Maiden Name Harriet Mead
15. Birthplace Balto

16 (a) Informant Wm L Thomas
(b) Address 504 N Caroline

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 (month) (day) (year)
(c) Cemetery or crematory Balto City
Location City

18 (a) Funeral director Ulrich Home
(b) Address 2 W Lexington Pl

JAN 6 1946
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan 4 1945; at 11 50 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Use death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Untreated generalized arteriosclerosis
Calcific Aortic Stenosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Sutton M.D.
Medical Examiner.
Date signed Jan 4 1945

(Over)

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEPhardt X ✓ G36062

G36062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36062

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 Murdock Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Lephardt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leo R Lephardt

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 26 1884

8. AGE: Years 59 | Months 7 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name John Raum
13. Birthplace Germany

MOTHER
14. Maiden Name Kunigunde Bledstein
15. Birthplace Germany

16 (a) Informant Leo Lephardt
(b) Address 636 Murdock Rd

17 (a) Burial (b) Date thereof Jan 8
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulbrich Funeral Home
(b) Address 2008 Orleans St

19 (a) 1946 Huntington for Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to ____ 19__
and that I last saw h e alive on Jan 4 1946

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions Generalized arteriosclerosis. Coronary failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. M. Cundill M. D.

Address Mercy Hosp Date signed 1-4-46

VS-150

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36083
94484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-mo. 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No. 33 S. Dundalk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lyter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd 1872

8. AGE: Years 73 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sullivan Lyter (D
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Hecker (D
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan (month) (day) 7th (year)
(c) Cemetery or crematory Oak Lawn
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1st 1946 19 , at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2nd 19 45 to Jan. 1st 19 46, and that I last saw him alive on Jan. 1st 19 46

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardio-vascular disease and	
Due to coronary heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: as above and in addition of autopsy: Laennec's cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland, M.D.
Address B.C.H. Date signed 1/5/46

VS 150

G36064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312 Registered No. G36064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6515 Fait Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6515 Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna R Paul

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frank C Paul
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct 25 1873

8. AGE: Years	Months	Days	If less than one day
72	2	9	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER — 12. Name	James Perkins
FATHER — 13. Birthplace	Balto
MOTHER — 14. Maiden Name	Dont Know
MOTHER — 15. Birthplace	Balto

16 (a) Informant Frank C Paul
(b) Address 6515 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Eleanor St

19 (a) JAN 9 1946 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1946 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Jan 4 1946, and that I last saw h.. alive on Jan 3 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension Cardio-Vascular Lyr Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. R. Evans M. D.
Address 1 Liberty Parkway Date signed 1-5-46

VS 150

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G36065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Dundalk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Dundalk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bauernfeind

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Anna Bauernfeind
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1874

8. AGE: Years	Months	Days	If less than one day
71 72	5	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Confectioner
11. Industry or business Retired

FATHER
12. Name Christof Ferd Bauernfeind
13. Birthplace Germany

MOTHER
14. Maiden Name Sabina Beryl
15. Birthplace Germany

16 (a) Informant Sabina Bauernfeind
(b) Address 1114 Dundalk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7- (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (Date) Filed by registrar Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1946, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-44 19 to 1-3-46 19, and that I last saw h alive on 1-3-46 19

Immediate cause of death Arteriosclerosis (Generalized) — Duration 1

Due to

Due to

Other Conditions Hypertensive Cardiovascular Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.
Address 234 S Conkling Date signed 1-5-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Type or print in ink. Fill in all items. Be sure cause of death clearly and legibly.

G360:6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c.

G360:6 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Johns Hopkins Hosp~~
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 7209 Woodrow ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence A Fifer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M

6 (b) Name of husband or wife Elsie Fifer
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jul 12 1899

8. AGE: Years	Months	Days	If less than one day
50	5	23	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Tool Maker
11. Industry or business

FATHER
12. Name Leo Fifer
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Balto

16 (a) Informant Mrs Margaret Fifer
(b) Address 7209 Woodrow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Wirt Home
(b) Address 2108 Orleans St

19 (a) (b) Washington Williams, M. Registrar

JAN 8 1946
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1946, at 10:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Empyema
Due to crushed chest

Other Conditions Subarachnoid hemorrhage.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 2, 1946 M.
(b) Where did injury occur? Essex, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Bus collision

23. Signature Benedict Skotarekis M.D. Medical Examiner.
Date signed Jan 6, 1946.

(over)

G36067 ✓ G36067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 55C

G36067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 749 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 749 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Pinning,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John H. Pinning,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1864

8. AGE: Years 81 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife,

11. Industry or business at home

FATHER
12. Name Edward Evans,
13. Birthplace unknown,

MOTHER
14. Maiden Name Evans,
15. Birthplace unknown,

16 (a) Informant Mr. Irvin M. Penning,
(b) Address 1416 Northgate Road,

17 (a) Burial (b) Date thereof 1/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) 1946 (b) Huntington Williams, M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1946 19 , at 11:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1- 1945 to Jan. 2- 1946, and that I last saw h er alive on Jan. 2 1946

Immediate cause of death: Carcinoma of Thyroid — Duration: 2 mos 1 day

Due to:

Due to:

Other Conditions Arteriosclerosis — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. McDermott M. D.
Address 1136 Poplar Grove Date signed

VS 150

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

27. G36068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G36068 Registered No. 543

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ledwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1248 Maple Ave. Arbutus
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William J. Grace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Katherine R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1891

8. AGE: Years: 54 | Months: 2 | Days: 12 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Phillip Grace
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Ellinger
15. Birthplace Md.

16 (a) Informant Mrs. Katherine R. Grace
(b) Address 1248 Maple Ave Arb.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry H. Little
(b) Address 401 E Edmondson Ave.

19 (a) 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1946 at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1945 to Jan 4 1946 and that I last saw him alive on Jan. 4 1946

Immediate cause of death: Astroblastoma, right hemisphere — Duration: 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 7, 1945

Major findings of operation: Recurrent neoplastic growth in rt. temporal

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reece R. Boone, Jr. M.D.
Address University Hosp. Date signed 1/4/46

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

2A

G36069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G36069 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 Wilkens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nona Carey

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2230

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of ~~Husband~~ or wife Thomas P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1888

8. AGE: Years	Months	Days	If less than one day
57	6	10	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Comfy Mfg. Co.
11. Industry or business Examiner

FATHER
12. Name Chas. Hartzell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary O'Leary
15. Birthplace Balto. Md.

16 (a) Informant Mary J. Klein
(b) Address 322 W. Calhoun Ave

17 (a) Burial (b) Date thereof Jan. 7 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Kuhtze
(b) Address 4101 E. Monument Ave

19 (a) 1948 (Date filed by registrar) (b) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3. 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1945 to Jan 3 1946, and that I last saw her alive on Jan 3 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury,

23. Signature Albert Kennard M. D.
Address 1938 Wilkens Ave Date signed

correct age is especially important. Physicians: please write the

27.

BALTIMORE CITY HEALTH DEPARTMENT

G36070 CERTIFICATE OF DEATH 93D

Registered No. G36070

Please write or print information clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2636 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-19
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2636 Park Heights Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara M. Tauber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1875.

8. AGE: Years 70 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Conrad Tauber
13. Birthplace Germany

MOTHER 14. Maiden Name Christina Wahl
15. Birthplace Germany

16 (a) Informant Miss Lillian E. Tauber
(b) Address 2636 Park Heights Ave.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Jan. 7/46. (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director Harry A. Tuttle.
(b) Address 4707 Edmondson Ave.

19 (a) 8 1946 (Date rec'd by registrar) (b) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1946 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31/45 1946
and that I last saw h alive on 19

Immediate cause of death: Arteriosclerotic Cardiovascular disease

	Duration
Due to: Cardiac Failure	1 mos
Due to: Pulmonary Edema	2 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A. Weinstein M.D.
Address 4603 Park Heights Ave Date signed 1/5/46

VS 150

636071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 636071

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville Manor
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. 7, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hilias Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Frank Fields
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Pa. Adams Co. Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Stover
13. Birthplace Pa.

MOTHER 14. Maiden Name Isabella Hilderman
15. Birthplace Pa.

16 (a) Informant Ella F. Langford
(b) Address Ohio.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Frank H. Merrill
(b) Address Pikesville Md.

19 (a) (Date received by registrar) (b) Huntington Williams Undertaker

JAN 6 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1946 to 1-3 1946, and that I last saw h/her alive on 1/3 1946.

Immediate cause of death: Cardio Respiratory failure — Duration

Due to

Due to Cerebral Hemorrhage due to Hypertensive Cardio vascular disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Reaff Jr.
Address St. Agnes Hosp Date signed 1/4/46 M. D.

G36072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42C

Registered No. G36072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3914 Hudson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3914 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS F. O'CONNOR

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-6774

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret E. O'Connor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29th 1888

8. AGE: Years 57 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Secretary.

11. Industry or business International Longshoremen

FATHER
12. Name Hugh O'Connor
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto., Md.

16 (a) Informant Margaret E. O'Connor (Wife)
(b) Address 3914 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd. Balto. Co.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) JAN 7 - 1946 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th 1946, at 1:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Jan 3 1946 and that I last saw h[illegible] alive on Jan 1 1946

Immediate cause of death Cancer of Colon — Duration
Bronchogenic Cancer
of Lungs
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Krumeich M. D.
Address 722 O'Donnell Date signed 1/5/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36073 ORRION ✓ G36073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 W. North ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orrion McCauley

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1882

8. AGE: Years 63 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Benjamin F. McCauley
13. Birthplace Md

MOTHER
14. Maiden Name Emma Wilhelm
15. Birthplace Md

16 (a) Informant pt.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Woodlawn Md

18 (a) Funeral director Wilson Funeral Co
(b) Address 1219 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 7 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1946, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1945 to 1-5 1946 and that I last saw him alive on 1-5 1946

Immediate cause of death: Heart failure.

Due to: Cor Heart.

Due to: Pulmonary Congestion

Other Conditions: Hemiplegia
Carcinoma of lung.
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas E. Bradbeer M. D.
Address Univ. Hosp. Date signed 1-6-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

G36074 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers
(c) Hospital or institution:
Aged Home of M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Webster German

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Alice Estelle Germon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1870

8. AGE: Years	Months	Days	If less than one day
75	4	14	hr. min.

9. Birthplace Baltimore Co Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name David M German
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Mary A Carlett
15. Birthplace Bath Co Md

16 (a) Informant Virginia Savage
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Hilborn & Hilborn Inc
(b) Address 1217 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1946 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Jan 3 1946 and that I last saw h[illegible] alive on 1-3 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	12 hours
Due to Osteosclerosis	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arden J Davis M. D.
Address 800 N 32nd St Date signed 1/5/46

correct age is especially important. Physicians: please write the

G36075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G36075 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3709 SEVENTH ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 SEVENTH ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME REVERDY JOHNSON

3 (b) If veteran, name war NO
3 (c) Social Security Account No. NONE

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of ~~husband~~ or wife NELLIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 4, 1867

8. AGE: Years 78 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace ANNE ARUNDEL CO. Md.
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business

FATHER
12. Name ROBERT JOHNSON
13. Birthplace A.A. CO. Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant NELLIE JOHNSON
(b) Address 3709 SEVENTH ST

17 (a) BURIAL (b) Date thereof JAN. 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 (a) JAN 7 - 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 4 1946 at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-24 1945 to Jan-4 1946, and that I last saw h. 14 alive on Jan. 4 1946.

	Duration
Immediate cause of death Cerebral Hemorrhage	Dec. 24/46
Due to Arterio-Sclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Loeber M. D.
Address 320 Cathedral St Date signed 1/6/46

correct age is especially important. Physicians: please write the ... information should be carefully supplied. The ... the causes of death clearly and legibly.

VS 150

G36076 ✓ G36076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2529 Francis
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-3
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 Francis (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Margaret Mary Wiegel

3 (b) If veteran, name war — W
3 (c) Social Security Account No. — none

4. Sex F | 5. Color or race co | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Steven B. Wiegel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1883

8. AGE: Years 62 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home wife
11. Industry or business Out of one

FATHER
12. Name Patrick J. McGee
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Donnelly
15. Birthplace Ireland

16 (a) Informant Wm Wiegel
(b) Address 2529 Francis St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Co Inc
(b) Address 1217 E Cold Spring

19 (a) JAN 7 - 1946 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1946, at 1450 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Jan 5 1946 and that I last saw h.... alive on Jan 5 1946

Immediate cause of death Carcinoma of Uterus

	Duration
Due to Acute Metastases	1943
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1663 W Mont St. Date signed 1/6/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) Born
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 W. Ware st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ringold Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1- 1884

8. AGE: Years	Months	Days	If less than one day
61	11	28	hr. min.

9. Birthplace Talbot Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name David Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Millie
15. Birthplace Talbot County, Md.

16 (a) Informant Edward Pryston
(b) Address 206 Ware St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-5-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Archibald F. Gaddis
(b) Address 2111 Mc Culloh St. Baltimore Md.

19 (a) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 - 1945 at 10 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions Edema of lower extremities
Left inguinal hernia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.

Date signed 1-3-46

VS 151

636078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 a

Registered No. 636078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Regester Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Theodore Cromer

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	215-07-9124

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Eva Cromer
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) April 19, 1891

8. AGE: Years	Months	Days	If less than one day
54	8	17	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Roofer
11. Industry or business Bethlehem Steel . S. P.

FATHER
12. Name Joseph Cromer
13. Birthplace Germany

MOTHER
14. Maiden Name Anastasia Barton
15. Birthplace Germany

16 (a) Informant Mrs. Eva Cromer- widow
(b) Address 3412 Regester Lane

17 (a) Burial (b) Date thereof 1-8-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) 1-7-1946 (b) Huntingtown, Md.
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1946, at 1 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1946 to 1-5 1946.
and that I last saw him alive on 1-5 1946.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Coronary Artery Disease	
Due to Myocardial Damage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M E Robertson M. D.
Address St Joseph's Hosp Date signed 1-5-46

correct age is especially important. Physicians: please write the

VS 150

G36079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E G36079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3403 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3403 Southern Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE CATHELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mitchell K. Cathell
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1873

8. AGE: Years	Months	Days	If less than one day
72 73	4	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James F. Seth
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name ? Warner
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Wm. K. Cathell
(b) Address Fort. Ave. & W. Lawrence St.

17 (a) Burial (b) Date thereof 1-8-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL CEMETERY
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Filed JAN 7 1946 (b) Huntington Williams, M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 5 1946, at 1.30 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Jan 5 1946.
and that I last saw he alive on Jan 4 1946

Immediate cause of death	Duration
Carcinoma of Intestines	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 1943
Major findings of operation: Carcinoma of Intestines
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thos. L. Grady M.D.
Address 516 Harford Rd Date signed 1-5-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

VS 150

G36080 G36080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 N. Milton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County:
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Milton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY BEHN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-05-5182

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie K. Behn
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 5, 1877

8. AGE: Years 68 | Months 6 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Gas & Elec. Co. - Retired

FATHER
12. Name John Behn
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Lambrect
15. Birthplace Germany

16 (a) Informant Mrs. Carrie K. Behn
(b) Address 226 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 7 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1946, at 10.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7th 1945 to Jan 4th 1946, and that I last saw him alive on Dec 18th 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 2

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature H. J. Taylor M. D.
Address 100 N. Milton Date signed 1/6/46

G36081 ✓ G36081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. _____

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 S. Macon Street
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 71
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Macon Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM THOMAS MILLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-09-0136

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Addie E. Miller
6 (c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr.) Nov. 2, 1882
8. AGE: Years 63 | Months 2 | Days 3 | If less than one day ____ hr. ____ min.
9. Birthplace Parton, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Beth. Steel, SP. PT. Md.

FATHER
12. Name William M. Miller
13. Birthplace Balto. County

MOTHER
14. Maiden Name Sarepta Gore
15. Birthplace Baltimore County

16 (a) Informant Mrs. Addie Miller
(b) Address 217 S. Macon Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] (Date received by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1946, at 4.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Jan 5 1946 and that I last saw ____ alive on ____ 19____

	Duration
Immediate cause of death: Pulmonary Embolism	1/4/46
Due to	
Due to Chr. Leukemia	1/1/45
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Reamer M. D.
Address 701 W. Lexington St. Date signed 1/5/46

VS 150

36032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36032

Registered No. 1602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Wilkens Memorial Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby boy Taborsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1945

8. AGE: Years | Months | Days | If less than one day: 14 hr. 51 min.

9. Birthplace Union Memorial Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Emil A. Taborsky
13. Birthplace [illegible] ?

MOTHER
14. Maiden Name Louise Zaman
15. Birthplace Baltimore, Md.

16 (a) Informant hospital records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19. JAN 7 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945, at 9 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1945 to Dec. 31 1945 and that I last saw him alive on Dec. 31 1945.

Immediate cause of death: Resp. failure — Duration

Due to: ? Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary Raymond Streeter M. D.
Address Union Memorial Hop Date signed 12-31-45

VS 150

3196 X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Give information asked for carefully supplied. The

Chychla

G36083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G36083

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 S. Linwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 S. Linwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Felix V. Chychla

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1913

8. AGE: Years	Months	Days	If less than one day
32	-	12	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Stephen Chychla
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Afftowicz (Ofertowicz)
15. Birthplace Poland

16 (a) Informant Anthony Chychla
(b) Address 823 S. Linwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John T. Duda
(b) Address 2029 Hudson St.

JAN 7 - 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1946 at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation by strangulation

Due to

Other Conditions Lacerations of both wrists
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/5/46 at about 7:00 A.M.
(b) Where did injury occur? 823 S. Linwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Hung self & cut

23. Signature P. J. Turnbach M.D.
Medical Examiner.
Date signed 1/5/46

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G36084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G36084
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna L. Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 3-24-1921

8. AGE: Years	Months	Days	If less than one day
24	9	12	10 hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name Willie Stevens
13. Birthplace N. C.

MOTHER 14. Maiden Name Amie Harrison
15. Birthplace N. C.

16 (a) Informant Corvin Brown
(b) Address 402 N. Pearl st

17 (a) Burial, cremation, or removal (b) Date thereof 1-8-46 (month) (day) (year)
(c) Cemetery or crematory Danville Va
Location Danville Va

18 (a) Funeral director William A Jackson
(b) Address 916 Pond ave

19 (a) Date rec'd by Local Registrar JAN 7 - 1946 (b) Huntington Williams Md. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 19 46 at 12 mid-night

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to Exanguination, resulting from deep laceration of thigh severing femoral vessels.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-3-46 at 11 P. M.
(b) Where did injury occur? Dilmon & Edmondson Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Benedict Kutorelic M.D.
Medical Examiner
Date signed Jan 5, 1946

G36085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G36085

Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Mountcastle Parkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August J. Krause

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Theresa Gottschalk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-56.

8. AGE: Years 89 | Months 4 | Days 30 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business: Mail Carrier - retired

FATHER
12. Name: Leonard Krause
13. Birthplace: Md.

MOTHER
14. Maiden Name: America Sigmund
15. Birthplace: Md.

16 (a) Informant: I
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Louden Park
Location: 3801 Frederick Ave.

18 (a) Funeral director: John O. Mitchell & Son, Inc.
(b) Address: 1900 Eutaw Place

19 (a) (Date) 1946 (b) registrar: Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5-1946, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to 1-5-1946 and that I last saw h[im] alive on 1-5-1946.

	Duration
Immediate cause of death: Cerebro-Vascular Accident	26 days
Due to: Hypertensive Cardio-vascular disease	2 wks?
Due to: Arterio sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Herbert Brendler
Address: Johns Hopkins Hosp Date signed: 1/5/46

JAN 7 1946

VS 150

G36086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

Registered G36086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 97 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Maria Louise Lazar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife Charles A. Lazar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1846

8. AGE: Years	Months	Days	If less than one day
99 97	3	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Trump
13. Birthplace Penna.

MOTHER
14. Maiden Name Sarah Newbold
15. Birthplace Penna.

16 (a) Informant hospital records
(b) Address

17 (a) Cremation (b) Date thereof 1/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) Registrar

VS JAN 7 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1946, at 1 37 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1945 to Jan. 6 1946, and that I last saw her alive on Jan. 6 1946.

Immediate cause of death	Duration
Lobar pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robt. L. Allen
Address Union Memorial Hosp. Date signed 1/6/46 M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36037

TN. 97861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G36037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Van Fosson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2nd. 1898

8. AGE: Years	Months	Days	If less than one day
47	11	2	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Clerk & School Teacher
11. Industry or business

FATHER
12. Name John Van Fosson
13. Birthplace Maryland

MOTHER
14. Maiden Name Viola McGluckon
15. Birthplace Illinois

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Loudon Park, Edmondson

18 (a) Funeral director Edward Foulon
(b) Address 2317 Eutaw Place

JAN 7 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th 1946 19 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13th 1945 to Jan. 4th 1946 and that I last saw h er alive on Jan 4th. 1946

Immediate cause of death (a) Carcinoma of the ovary with metastasis — Duration 8 mos.
Due to (b) Cachexia
Due to (c) Anemia, Severe
Other Conditions Secondary to (d)
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roal E. Netterville M. D.
Address Baltimore City, Md. Date signed Jan 4, 1946

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. The

G36088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G36088 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The accuracy required.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3222 Ellerslie Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Ellerslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles K Gayleard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, widowed, or ~~divorced~~.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18/1857

8. AGE: Years 88 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Iron Molder

11. Industry or business

FATHER 12. Name Frank Gayleard
13. Birthplace Md.

MOTHER 14. Maiden Name Rachael Coulbourn
15. Birthplace Md.

16 (a) Informant Rhoda Gayleard
(b) Address 32 22 Ellerslie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Western
Location Edgemont Ave.

18 (a) Funeral director Edw Loudspeaker
(b) Address 2359 West Blvd

19 (a) JAN 7 1946 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/45 19 , to 1/5/46 , and that I last saw h[illegible] alive on 1-5-46

Immediate cause of death Myocardial Degeneration — Duration 24 hrs

Due to Arteriosclerosis — 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. K. Herrman M.D.
Address 1710 E. 33rd St. Date signed 1/6/46

G36089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G36089 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1958 Annapolis Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Irene Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or ~~divorced~~
F 58	W	W

6 (b) Name of husband or wife Not living

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Grocery Store

11. Industry or business

FATHER
12. Name
13. Birthplace Dec John Eadler

MOTHER
14. Maiden Name Dec
15. Birthplace

16 (a) Informant Ethel Griffin
(b) Address 1958 Annapolis ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Edw Faulkner
(b) Address 4329 Wash Blvd

19 JAN 7 - 1945 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1945 at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1945, to 1-5 1945 and that I last saw h~~e~~r alive on 1-5 1945

Immediate cause of death	Duration
Heart failure	
Due to Chronic dilated heart	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas E. Bradshaw M. D.
Address University Hosp. Date signed 1-5-45

1501

G36090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36090 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Use only black ink or typewriter supplies. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Brentwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Lillie E. Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/26/~~1870~~ 1870

8. AGE: Years	Months	Days	If less than one day
75 76	11	9	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfred Edwards
13. Birthplace Va.

MOTHER
14. Maiden Name Melina Garrett
15. Birthplace Va.

16 (a) Informant Charles W Johnson
(b) Address 1626 Gaylord St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Ridge
Location Wash Blvd.

18 (a) Funeral director Edw Tomson
(b) Address 2359 Wash Blvd

19 JAN 7 - 1946 (b) Huntington Willis Richards
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/ 1946 to 1/4 1946, and that I last saw her alive on 1/4 1946

Immediate cause of death	Duration
Bronchial Pneumonia	1 week
Due to	
Due to	
Other Conditions Bronchial Asthma Arteriosclerosis - Chronic C.V.D. Anemia	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum
Address 1206 E Preston Date signed 1/5/46

10 (over) 107

G36091 ✓ G36091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1550 N. Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days) 62

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1550 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Gibson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Harry Gibson
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb 17 1879

8. AGE: Years	Months	Days	If less than one day
66	10	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman Fuhler
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Tonsel
15. Birthplace Germany

16 (a) Informant Mrs. Catherine Gibson
(b) Address 1550 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 7 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946, at 2:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946 to Jan 4 1946, and that I last saw h[illegible] alive on Jan 4 1946.

Immediate cause of death	Duration
Due to Chr. Myocarditis	1940
Due to Chr. Interstitial Nephritis	1940
Other Conditions Right Hemiplegia (Include pregnancy within 3 months of death)	Nov. 43

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daisy Brown
Address 1663 Monta Ave Date signed 1/9/46

G36092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered No. G36092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 N. Payson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 N. Payson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Pfeffer

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-1875

8. AGE: Years	Months	Days	If less than one day
70	11	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name	? Meinhake
FATHER 13. Birthplace	?
MOTHER 14. Maiden Name	?
MOTHER 15. Birthplace	?

16 (a) Informant Mrs. Geo. W. Pfeffer
(b) Address 1907 N. Payson st

17 (a) Buried (b) Date thereof 1-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Cem.
Location Balto, Md.

18 (a) Funeral director Wm. J. Lukemeyer Son.
(b) Address North & Payson

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

JAN 7 51 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1946, at 4 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-3-46 at P. M.
(b) Where did injury occur? 1907 N. Payson St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Unlit gas jets, kitchen range

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-4-46

BALTIMORE CITY HEALTH DEPARTMENT

G36093 — CERTIFICATE OF DEATH — 1946 — B36093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Chestnut Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E. Keller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Irene Keller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-1887

8. AGE: Years 58 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Irene M. Keller
(b) Address 4008 Chestnut Ave

17 (a) Burial (b) Date thereof 1-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Loudon Park Cem

18 (a) Funeral director Wm. J. Tuckerman Son
(b) Address North & Pd. Ave.

19 (a) JAN 7 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1946, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Lubinski M.D.
Medical Examiner.
Date signed 1-7-46

G36094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92D

G36094 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Use typewriter supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 338 E. 25th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 E. 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Garnet Foster

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1856

8. AGE: Years 89 | Months 4 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None —

11. Industry or business

FATHER
12. Name William A. Foster
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Maria English
15. Birthplace Baltimore, Md.

16 (a) Informant Nettie F. Foster
(b) Address 338 E. 25th ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount —
Location Baltimore, Md.

18 (a) Funeral director Howard A. Covington
(b) Address 21 W. 25th ST.

19 (a) [illegible] (b) [illegible]
JAN 7 1946 Hattie F. Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6- 1946, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1946 to 1-6- 1946, and that I last saw h[illegible] alive on 1-5- 1946.

Immediate cause of death	Duration
Due to Chronic Myocarditis	years
Due to Old Age.	
Other Conditions Acute Dilatation	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Hyslop C Black M. D.
Address Med Arts Bldg Date signed

G36095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100

G36095 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 174- Dolphin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 174- Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Baker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4 1879

8. AGE: Years 67 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Farmville Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Baker

13. Birthplace Va.

MOTHER 14. Maiden Name Lucie ?

15. Birthplace Va.

16 (a) Informant Bertha Britton

(b) Address 174- Dolphin St.

17 (a) Burial (b) Date thereof 1-7-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918- Druid Hill Ave

19 (a) (Registrar's signature) JAN 7 1946 Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1946 at 12:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1945, to Jan 3 1946, and that I last saw h[illegible] alive on Jan 2 1946.

Immediate cause of death	Duration
Lobar Pneumonia	7 days
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury PELLEKAIN

23. Signature H. C. Pelletan M. D.
Address 417 Hamilton Ter Date signed 1-5-46

VS 150

AB -7[illegible]6096 — 636096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. [illegible]

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3yrs- 9mos-11 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 846 Tyson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Sarah Myers

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel (D)

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June ?-?- 1862

8. AGE: Years: 83 ? Months: 5 Days: ? If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: Major Freeman
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mariah Carter
15. Birthplace: Md.

16 (a) Informant: Baltimore City Hospitals (Records)
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cemetery
Location: [illegible]

18 (a) Funeral director: Adolphus Halstead
(b) Address: 918- Druid Hill Ave.

19 (a) JAN 7 - 1946 (Date rec'd by registrar) Registrar: Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28- 1945, at 7.50PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1942, to 12-28 1945, and that I last saw h er alive on 12-28 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: T. P. Jernigan M. D.
Address: Baltimore City Hosp. Date signed 1-3-47

G36097
4829494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 D

G36097
Registered No.

Correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 N. Pace St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Shaw.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-20-44.

8. AGE: Years	Months	Days	If less than one day
1	4	15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Easton Staton
13. Birthplace N. C.

MOTHER
14. Maiden Name Selma Shaw
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Clarkton N. C.
Location N. C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Pleasant Hill Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 7 - 1946

VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1946 at 8.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Jan. 4 1945, and that I last saw h[illegible] alive on Jan. 4 1945

Immediate cause of death	Duration
Heart failure.	3 hrs.
Due to Chronic Myocarditis	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter M. Tasen M. D.
Address J. H. H. Date signed 1-5-46

X

636098
98125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 098

Please write the causes of death clearly and legibly. Physicians: please write the correct age especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 N. Robinson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William ~~Killam~~ Killman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-1296

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise Killman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12th. 1888

8. AGE: Years	Months	Days	If less than one day
57	2	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Maintenance Man
11. Industry or business First Nat. Bank Bldg

FATHER
12. Name Thomas Killman
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Nemmer
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address ~~Bal~~ 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Jan. 7-46
(Burial, cremation, or removal) (month) (day), (year)
(c) Cemetery or crematory Oak Lawn Elm.
Location Eastern Ave.

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

19 JAN 7 1946
(Date received by Registrar)

Registrar

VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th. 1946 19 , at 9.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 19 45 to Jan. 4 19 46 and that I last saw him alive on Jan. 4th 19 1946

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 1/4/46

G36099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

Registered No. G36099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland HARLEM
(b) Street address 954 Dolan Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 954 Dolan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Elizabeth Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1945

8. AGE: Years | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Josephine Lewis
15. Birthplace Baltimore Md

16 (a) Informant Elizabeth Lewis
(b) Address 954 Dolan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 222 N. Schroeder St.
JAN 7 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946 to 19 and that I last saw him alive on Jan 4 1946

Immediate cause of death: Bronchio-pneumonia — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts

Address 515 Huntington Ave Date signed 1/7/46 M. D.

VS 150

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Space is especially important. Use only black ink. Do not use pencil. Do not write in margins. Do not use abbreviations. Do not use ditto marks. Do not use arrows. Do not use brackets. Do not use parentheses. Do not use quotation marks. Do not use underlining. Do not use italics. Do not use boldface. Do not use capitals. Do not use numbers. Do not use symbols. Do not use fractions. Do not use decimals. Do not use percentages. Do not use ratios. Do not use proportions. Do not use averages. Do not use medians. Do not use modes. Do not use ranges. Do not use standard deviations. Do not use variances. Do not use correlations. Do not use regressions. Do not use tests. Do not use hypotheses. Do not use theories. Do not use models. Do not use simulations. Do not use experiments. Do not use observations. Do not use data. Do not use information. Do not use knowledge. Do not use wisdom. Do not use understanding. Do not use insight. Do not use intuition. Do not use guesswork. Do not use speculation. Do not use conjecture. Do not use opinion. Do not use belief. Do not use faith. Do not use hope. Do not use prayer. Do not use meditation. Do not use contemplation. Do not use reflection. Do not use introspection. Do not use self-examination. Do not use self-analysis. Do not use self-knowledge. Do not use self-understanding. Do not use self-insight. Do not use self-intuition. Do not use self-guesswork. Do not use self-speculation. Do not use self-conjecture. Do not use self-opinion. Do not use self-belief. Do not use self-faith. Do not use self-hope. Do not use self-prayer. Do not use self-meditation. Do not use self-contemplation. Do not use self-reflection. Do not use self-introspection. Do not use self-examination. Do not use self-analysis. Do not use self-knowledge. Do not use self-understanding. Do not use self-insight. Do not use self-intuition. Do not use self-guesswork. Do not use self-speculation. Do not use self-conjecture. Do not use self-opinion. Do not use self-belief. Do not use self-faith. Do not use self-hope. Do not use self-prayer. Do not use self-meditation. Do not use self-contemplation. Do not use self-reflection. Do not use self-introspection.

636100

TN. 97946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

636100

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 124 S. Collington Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Anna Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Francis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15th. 1915

8. AGE: Years 30 | Months 6 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: Frank Prentki

13. Birthplace: Poland

MOTHER

14. Maiden Name: Madeline Pesko

15. Birthplace: Poland

16 (a) Informant: Baltimore City Hospitals

(b) Address: 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 8/46 (month) (day) (year)

(c) Cemetery or crematory: ST. STANILAUS

Location: DUNDALK AVE.

18 (a) Undertaker or funeral director: Lilly & Zeiler inc.

(b) Address: 1545 S. WOLFE ST.

JAN 7 - 1946

19 (a) ____ (Date received by registrar) (b) Huntington Williams, M.D.

JAN 7 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5th. 1946 19 ____ at 6.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18th 19 45 to Jan. 5 19 46 and that I last saw her alive on Jan. 5th 19 46

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: Herbert B. Boland Jr. M.D.

Address: Balt. City Hosp. Date signed 1/6/46

G36101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

Registered No. G36101 (new)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINIA HOSP. 2-W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO. 3
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 FLEET ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Malinowski

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ROSALIE ANNA MALINOWSKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 25 1880

8. AGE: Years	Months	Days	If less than one day
65	5	12	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation CLOTHES PRESSER

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant ROSALIE ANNA MALINOWSKI (WIFE)
(b) Address 1704 FLEET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 9/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) JAN 7 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1946 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1946 to 1-6 1946 and that I last saw h wife alive on 1-6 1946

Immediate cause of death Rupture of descending aneurysm — Duration

Due to Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Feinstein M.D.
Address Emerg. Hospital Date signed 1-8-46

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G36102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 ashland ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 ashland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie J. McArthur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sandy McArthur Deceased | 6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years: 60 | Months | Days | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Jack McNeil

13. Birthplace North Carolina

MOTHER 14. Maiden Name Ellie Drake

15. Birthplace North Carolina

16 (a) Informant Henry McArthur

(b) Address 1404 Ashland Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-7-1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Lottie Gregg

18 (a) Funeral director

(b) Address 1408 ashland Ave

19 (a) (b)

JAN 7 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 4 1946, at 2:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 1 1946 to JAN. 4 1946 and that I last saw h.. alive on JAN. 4 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 hrs

Due to: Hypertension

Due to: Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Albert L. Lafuse M.D.

Address 822 N. Bond St Date signed 1/5/46

G36103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36103

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Lansing Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Lansing Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E Snyder

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1866

8. AGE: Years 79 | Months 4 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Joseph L Snyder
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sidonia Harpmyer
15. Birthplace Baltimore Md

16 (a) Informant Mrs Joseph L Williamson
(b) Address 1714 Lansing Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road Balto Md

18 (a) Funeral director
(b) Address 1735 Hanford Avenue

19 (a) JAN 7 1946 Huntington Williams, M.D. Address 733 Asquith St Date signed 1/6/46

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5th 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945 to Jan 1 1946 and that I last saw h[illegible] alive on Jan 1 1946.

Immediate cause of death: Acute Coronary Infarction — Duration
Due to: Ch Coronary Sclerosis
Due to: Ch Hypertention
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A.H. Thomsteen M. D.

Knode

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G36104

G36104 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Arbutus Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rose Knode

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Emory B. Knode
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) June 30, 1885

8. AGE: Years	Months	Days	If less than one day
60	6	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER	12. Name Charles H. Brunier
	13. Birthplace Germany
MOTHER	14. Maiden Name Emma Wilhelm
	15. Birthplace Germany

16 (a) Informant Charles B. Knode
(b) Address 1525 Arbutus ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Coles
(b) Address 1300 N. Lombard St.

JAN 7 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1946 to 1-5 1946, and that I last saw h[illegible] alive on 1-5 1946.

Immediate cause of death: Acute Cardiac Failure — Duration

Due to:

Due to Hypertension Cardio Vasc Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clift Laslett Jr.
Address St. Agnes Hosp Date signed 1/5/46

VS 130

36105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registered No. G36105

Please answer all questions as completely as possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 20 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore City, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 Lemmon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** John Aseman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Minnie Aschmann 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	6	hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob Aseman
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Fellenz
15. Birthplace Germany

16 (a) Informant Frederick A. Cole
(b) Address 1200 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St

19 Date received by local registrar JAN 7 1946 (b) Transcriber for Williams

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 1-3-46 19 ; at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1945 to 1-3 1946, and that I last saw him alive on 1-3 1946.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Anaemia	
Due to	
Other Conditions Fractured Femur	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec. 29 1945 M
(c) Where did injury occur? Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no (Specify type of place)
(e) Means of injury fell down stairs

23. Signature H. M. Seabolt M. D.
Address Community Hosp. Date signed 1-4-46

Howard J. Apuzzio, M. D.

G36106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 E Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 362 Floyd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Osher Adelman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rhoda Adelman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Rheumatism

11. Industry or business

FATHER
12. Name David -
13. Birthplace Poland

MOTHER
14. Maiden Name Rachael -
15. Birthplace Poland

16 (a) Informant Abraham Adelman
(b) Address 4827 Park Hgts. Ave

17 (a) Burial
(Burial, cremation, or removal) Date thereof 1-7-46
(month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location

18 (a) Funeral director Jacob Heims Inc
(b) Address 1730 E. Balto. St

19 Filed JAN 7 1946 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1946 at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Gluck M.D.
Medical Examiner.

Date signed January 46

G36107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Lunacy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Lorman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Opera Burman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Rose Burman
(b) Address 1709 Lorman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location E. Balto

18 (a) Funeral director Jack Lawrence
(b) Address 1409 E Balto St

19 (a) JAN 7 1946 (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH January 6 1946, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1945, to 1/6 1946, and that I last saw h[illegible] alive on 1/5 1945.

Immediate cause of death	Duration
Thrombosis Coronary	
Due to Arteriosclerotic heart dis	
Due to	
Other Conditions Thrombosis Coronary	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas D. Fuchs

Address Sinai Hospital Date signed 1/6/45 M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G36108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline Sts.
(c) Hospital or institution: St. Joseph's Hospital. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 N. Paterson Pk.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Mickal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/7/43

8. AGE: Years 2 1/2 | Months 8 | Days 28 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Michael Mickal
13. Birthplace Virginia (Sweetvale)

MOTHER
14. Maiden Name Mary Catarski
15. Birthplace Florida Penna.

16 (a) Informant Michael Mickal
(b) Address 201 N. Paterson Pk.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run - Shipley Sta.

18 (a) Funeral director Chas W. Schafferman
(b) Address 637 Washington Blvd

19 Filed JAN 7 1946 Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1946 at 9-16 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1946 to 1/5 1946, and that I last saw h[illegible] alive on 1/5 1946.

Immediate cause of death: Cardio Respiratory Failure — Duration:
Due to: Bronchopneumonia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address St. Joseph's Date signed 1/5/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G36109

Please write the causes of death clearly and legibly. Physicians: please write correct age if apparently important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 9mo
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Kearney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife James C. Kearney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	4	18 hr. min.

9. Birthplace Baltimore Md U S A
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Patrick McKeever
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice Linott
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (b) Date thereof Jan 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Bela Wiedefeld
(b) Address 914 Greenmount Ave

19 (DAN 7 - 1946) Huntington Williams Mgr
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-4- 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1- 1946, to Jan 4- 1946, and that I last saw her alive on Jan 4- 1946.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic myocarditis	2 yrs
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 1/5/46

VS 150

G36110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Brendan Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Brendan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank (Ranehan) RENEHAN

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 12, 1894

8. AGE: Years	Months	Days	If less than one day
51	7	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation TELE OPERATOR
11. Industry or business WESTERN Dist - Police Dept

FATHER
12. Name John M RENEHAN
13. Birthplace Ireland

MOTHER
14. Maiden Name DELIE McDonald
15. Birthplace Ireland

16 (a) Informant HELEN RENEHEN
(b) Address 3114 BRENDAN AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) JAN 7 - 1946 (Date rec'd by registrar) Huntington Williamson, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1946, at 1:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to, his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Pulaski Medical Examiner. M.D.
Date signed 1/5/46

VS 151

G36111 G36111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Valley St D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Valley St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ellen Duffy

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 82 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home work at
11. Industry or business Home

FATHER
12. Name Peter Duffy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McGowan
15. Birthplace Ireland

16 (a) Informant Miss Mary E. Duffy
(b) Address 1007 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6, 194 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Signature of local registrar) (b) Huntington Williamsport, Md.

JAN 7 - 1940

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1940, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Turbin Jr. M.D.
Medical Examiner
Date signed 1/6/40

G36112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 B

Registered No. G36112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 E. Lafayette Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mrs. Beulah Pritchett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	

6 (b) Name of husband or wife Mr. William Pritchett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/28/07

8. AGE: Years	Months	Days	If less than one day
38	5	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. H. Smoot
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Florence Taylor
15. Birthplace Balto. Md.

16 (a) Informant Wm. R. Pritchett
(b) Address 1730 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/46 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director E. J. Pfeiffer & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (Date received by Registrar) JAN 7 1946 (b) Registrar Huntington Williamsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/46 19 at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/45 to 1/5 1946 and that I last saw he alive on 1/5 1946.

Immediate cause of death: Congestive heart failure — Duration: 2 wks.
Due to: Rheumatic C.V.D. with mitral stenosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. L. Mikel Jr. M.D.
Address Bon Secours Hosp. Date signed 1/5/46

X

G36113 BALTIMORE CITY HEALTH DEPARTMENT G36113

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Poplar Grove
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles or Pasquale Battaglia

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of ~~husband or~~ wife Concetta Battaglia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16. 1883

8. AGE: Years	Months	Days	If less than one day
62	3	21 2/0	hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Pasquale Battaglia
13. Birthplace Italy

MOTHER
14. Maiden Name Giuseppina Curriori
15. Birthplace Italy

16 (a) Informant Concetta Battaglia (Wife)
(b) Address 743 Poplar Grove St.

17 (a) Burial (b) Date thereof Jan. 9 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) JAN 7 1946 Registrar
(Date received)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Jan 6 1946
and that I last saw him alive on Jan 5 1945

Immediate cause of death	Duration
Chronic Bronchitis & Emphysema	2 yrs.
Due to	
Due to	
Other Conditions Arteriosclerosis C.V.D.	2 yrs
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 301 Thruston Date signed 1/6/46

Use write the causes of death clearly and legibly. Correct age is especially important. Physicians: please w

G36114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 81a

G36114 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Ashland Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME William C. KIRCHNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife TERESA KIRCHNER (nee Kantor) 6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) APRIL 14, 1895

8. AGE: Years	Months	Days	If less than one day
50	8	22	hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation Supt. of apartments
11. Industry or business

FATHER
12. Name John Kirchner to wife
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Brooks
15. Birthplace Baltimore, Md.

16 (a) Informant wife TERESA KIRCHNER
(b) Address 2425 ASHLAND AVE, BALTO

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar Williams, M.D.

VS 130 JAN 7 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1946 at 6 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946, to Jan 6 1946, and that I last saw him alive on Jan 6 1946.

Immediate cause of death	Duration
Meningitis	1 day
Due to pneumococcus	
Due to	
Other Conditions hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed 1-6-46

G36115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G36115 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4704 Holabird Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4815 Holabird Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY TRAU

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~: Joseph Trau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1862

8. AGE: Years	Months	Days	If less than one day
83 yrs.	4	24	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Kocum
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Anna Hammen - daughter
(b) Address 4815 Holabird Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Horners Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) Huntington Williams JAN 7 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1946 at 3:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945 to Jan 4 1946, and that I last saw h~~er~~ alive on Jan 3 1946.

Immediate cause of death: Arteriosclerosis C.V. Disease — Duration: Nov 12/45
Due to Chronic Myocarditis — Dec. 24/45
Due to Fractured Femur
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Schimunek M.D.
Address 842 S. Eden St. Date signed 1-4-46

G36116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1647a

Registered No. G36116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Mura Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James John Novak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1904

8. AGE: Years	Months	Days	If less than one day
41 yrs.	4	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Atlantic, Pacific Broom Works

FATHER
12. Name Martin Novak
13. Birthplace Prussia

MOTHER
14. Maiden Name Mary Jankowski
15. Birthplace Prussia

16 (a) Informant Mary Vowers
(b) Address 2605 Mura Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) JAN 7 1946 (b)
(Date filed by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1946 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 5 1946 M.
(b) Where did injury occur? 1400 Block Edison Hgwy
(c) Did injury occur at home, on farm, industrial place, in public place? Farm While at work? No
(d) Means of injury Hanging

23. Signature Benedict Abstarelis M.D.
Medical Examiner.
Date signed Jan 6, 1946.

Huntington Williams M.D.

G36117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G36117 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1648 N. Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1648 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson B. Block

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine M. Block
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1903

8. AGE: Years	Months	Days	hr.	If less than one day min.
42	10	16		

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business British Airways

FATHER
12. Name Ernest B. Block
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Frances Wilson
15. Birthplace Va.

16 (a) Informant Mrs. Catherine M. Block
(b) Address 1648 N. Fulton Ave.

17 (a) Burial (b) Date thereof 1/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

AM 1 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6, 1946, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotzelis M.D.
Medical Examiner.
Date signed Jan 6, 1946

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36118 (Registered No.)

G36118 / 93c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Block E. Monument st
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 N. Payson st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Bayarsky Barr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 71 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Hyman Sears
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah Rachel
15. Birthplace Russia

16 (a) Informant Mrs. Isidore Barr
(b) Address 1506 N. Payson st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton ave & Philadelphia Rd

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W. North ave

19 (a) JAN 7 1946 (Registrar's certificate) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7/46 1946 at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 1/7 1946, and that I last saw her alive on 1/7 1946

Immediate cause of death Cardio-respiratory failure — Duration

Due to Heart disease (arterio-sclerotic) Lenuatic D

Due to & bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harrison Rinde M. D.

Address Sinai Hosp Date signed 1/7/46

X

Please write the causes of death clearly and legibly. Physicians: please write correct age if especially important.

G36119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G36119 Registered No.

Please answer all questions in ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2617 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Edward Meyer

3 (b) If veteran, name war: W.W. II
3 (c) Social Security Account No. 705-05-4065

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30. 1910

8. AGE: Years 35 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B & O. R.R.

FATHER 12. Name Otto E. Meyer
13. Birthplace Germany

MOTHER 14. Maiden Name Louise Ullmann
15. Birthplace Austria

16 (a) Informant Mrs. Frank E. Morrison
(b) Address 2617 Walkens Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn.

18 (a) Funeral director Thomas J. Kennington
(b) Address 1600 Hollins St.

19 (a) JAN 7 - 1946 (Date received by registrar) Huntington Williams, M.D. (Address) 251 Wilkens Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1946, at 4.05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Jan 5 1946 and that I last saw him alive on Jan 6 1946

Immediate cause of death: Pulmonary Oedema — Duration
Due to: Myocarditis, Mitral Insufficiency — Duration
Due to: Essential Hypertension — Duration
Other Conditions: Malnutrition — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. C. Williams M.D. Date signed 1/7/46

VS 150

636120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

636120

Correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Eaton Aves
(c) Hospital or institution: St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. W Ellicott City
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Ballew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Everett
6 (c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.) 1-16-1902

8. AGE: Years 43 | Months 11 | Days 22 | If less than one day: hr. min.

9. Birthplace Lancaster Pa.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Hugh Portello
13. Birthplace Pa

MOTHER
14. Maiden Name Anna Webber
15. Birthplace Pa

16 (a) Informant Everett Ballew
(b) Address Ellicott City Md.

17 (a) Burial (b) Date thereof 1-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Road

18 (a) Funeral director John F Miller Inc
(b) Address 2435 E Oliver St.

19 (a) (b)
(Date rec'd by registrar)
JAN 7 - 1946

Huntington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946, at 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1946, to 1-6 1946, and that I last saw h[illegible] alive on 1-6 1946.

Immediate cause of death Uremia
Cardio-Respiratory Failure

Due to Chronic Rheumatic Cardio-Vascular disease.

Due to

Other Conditions Marked Cyanosis.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur T. Hill Jr. M. D.
Address St. Agnes Hosp. Date signed 1/6/46

X

G36121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36121 Registered No.

Type or print the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 N. Patterson Pk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Bleume

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5983

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	wh	M.

6. (b) Name of husband or wife Anna
6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) March 24 1880

8. AGE: Years	Months	Days	If less than one day
65	9	11	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Manager
11. Industry or business American Store

FATHER
12. Name Fred Bleume
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Zink
15. Birthplace Unknown

16 (a) Informant Anna Bleume
(b) Address 1434 N. Patterson Pk Ave.

17 (a) Burial (b) Date thereof 1-8-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location North Ave

18 (a) Funeral director John C. Miller Sec
(b) Address 2435 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 7 - 1946 Huntington Station, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 4 1946 and that I last saw him alive on Jan 4 1946.

Immediate cause of death	Duration
Cerebral Embolus	
Due to Renal Thrombosis	
Due to Coronary Thrombosis	
Other Conditions Hypertensive Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Butler M. D.
Address Univ Hosp Date signed 1-4-46

G36122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V198

G36122 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 13 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County ??
(c) City or town Templeville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Fields

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eden Laws Fields
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 15, 1906

8. AGE: Years 39 | Months 8 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Wattsville, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Fields
13. Birthplace Quantico, Va.

MOTHER
14. Maiden Name Ella Sarge
15. Birthplace New Church, Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 7 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1945 at 12.17 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3rd 1945 to Dec. 28 1945 and that I last saw him alive on Dec. 28 1945

Immediate cause of death	Duration
Dislocation of 5th Cervical vertebra	
Due to Dislocation	
Due to Execution by hanging	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Sybrey
Address Temple Court Apts. Date signed 12-28-45

VS 250

3206

636123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 636123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 Augusta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peppio Palucci

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 7 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945, at 8:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Fraiser M.D. Medical Examiner
Date signed 12-24-45

VS 151

3205

G36124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G36124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's 9, 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Eden street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Mannah

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			....hr. ....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School JAN 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) JAN 7 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

F 3204

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25th 1945, at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured cervical vertebrae

Due to.....

Other Condition Extra abdominal injuries.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/25/45 9/9 10:30 A.M.
(b) Where did injury occur? 1420 Eden st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Jumped from [illegible]

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-25-45

X

636125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

Registered No. 636125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~607 Mon~~
(c) Hospital or institution: Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~609 North Fulton~~ 609 N. Monroe St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Morris

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-1799

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Gertrude Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1881

8. AGE: Years	Months	Days	If less than one day
64 (20)			hr. min.

9. Birthplace Liverpool England (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Gertrude Morris
(b) Address 1910 Englewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Johns Hopkins Medical School JAN 7 1946

18 (a) Funeral director Wm. Commissioner for Hebrew Sinai
(b) Address North & Pulaski Aves

19 (a) JAN 7 1946 (Date rec'd by registrar) (Signature of Registrar) Wm. Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/45 19..., at 10:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P. Davis M.D.
Medical Examiner.
Date signed 1/2/46

F 3203

G36126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36126 Registered No.

Write the cause of death clearly and legibly. Correct age if apparently inaccurate. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 S. Calverton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Calverton Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis A. Murphy

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Stella C. Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 5, 1876

8. AGE: Years 70 | Months 11 | Days 26 | If less than one day: hr. min.

9. Birthplace Charles County, Md. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business St. Benedicts Church

FATHER
12. Name Francis A. Murphy
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Bridgett
15. Birthplace Maryland

16 (a) Informant Stella C. Murphy
(b) Address 106 S. Calverton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Lloyd L. Schwab
(b) Address 2101 Fredrick Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md.

VS Form 1 JAN 7 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1946, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1945 to Jan 5 1946, and that I last saw h. l. m. alive on Jan 4 1946.

Immediate cause of death: Bronchio-pneumonia — Duration: 7 Days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/5/46

G36127 W Shanahan

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G36127

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 S Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 8 S Monroe St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C McInerney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26 1880

8. AGE: Years 65 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Michael McInerney
13. Birthplace Ireland

MOTHER
14. Maiden name Bridget Shanahan
15. Birthplace Loveland

16 (a) Informant Mrs J M Sweeney
(b) Address 8 S Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Paris Md

18 (a) Funeral director Geyer & Shirley
(b) Address Fulton & Fayette

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D. Address

JAN 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1946 to 1/6 1946 and that I last saw her alive on 1/2 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to: Hypertension — Duration 2 years

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel L Haughton
Address 1945 W Baltimore Date signed 1/7/46

G36128 ✓ G36128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4229 Old Frederick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4229 Old Frederick
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Stromberg ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph P.
(c) If give, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1873

8. AGE: Years 72 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Luke Carr
13. Birthplace Ireland

MOTHER
14. Maiden name Elizabeth Carr
15. Birthplace Ireland

16 (a) Informant Joseph P. Stromberg
(b) Address 2442 Maiden St

17 (a) Burial (b) Date thereof 1-8-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Eugene F. Tyler
(b) Address Fulton Ave & Fayette

19 (a) (Date rec'd by Registrar) (b) Registrar's signature

1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1937 to Jan 4 1946 and that I last saw h[illegible] alive on Jan 4 1946.

Immediate cause of death: Lobar Pneumonia — Duration 3 days

Due to Cardio Vascular Renal & Hypertension — 3 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Fruitland Ave Date signed

VS 150

20.

G36129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G36129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 abington Ave
(c) Hospital or institution: 20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18. Abington Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kata Michel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widow

6 (b) Name of husband or wife Nate Steven Michel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1881

8. AGE: Years	Months	Days	If less than one day
64	1	12	hr. min.

9. Birthplace Yugoslavia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER	12. Name Jakob Andres
	13. Birthplace Yugoslav
MOTHER	14. Maiden Name Jhyostose
	15. Birthplace

16 (a) Informant George C. Michel
(b) Address 1 S. Abington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8 '46 (month) (day) (year)
(c) Cemetery or crematory Larraine Pk
Location Woodlawn, Md.

18 (a) Funeral director Harry H. Nikitas
(b) Address 4101 E. Monument Ave

19 (a) Filed JAN 9 1946 Huntington Williams, M.D. Registrar
(Date filed) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1946 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1945, to 1/4 1946.
and that I last saw h alive on 19

Immediate cause of death	Duration
General Carcinomatosis	9 Months
Due to Carcinoma of Stomach	2 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson MD M. D.
Address 432 Medical Arc Date signed

G36130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G36130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Millington Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days) 8 0 0 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Millington Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Amelia Gaffney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1859

8. AGE: Years 86 | Months 2 1 | Days | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward Gaffney
13. Birthplace Md.

MOTHER
14. Maiden Name Christianna Cramer
15. Birthplace Penn.

16 (a) Informant Mrs. Pearl Bullinger
(b) Address 505 Millington Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9/46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery Edmondson Ave & Longwood St

18 (a) Funeral director Harry H. Lichte
(b) Address 401 E. Edmondson Ave

19 (a) JAN 7 - 1946 (Date registered) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Jan 5 1946, and that I last saw h[illegible] alive on Jan 4 1946.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Arteriosclerosis	
Due to Endocarditis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur O. Peters

Address 215 Hilton Ave Date signed 1/7/46

VS 150

G36131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

G36131 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Manne Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York city (If outside city or town limits, write RURAL and give town)
(d) Street No. 262 W 127 St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Pfc. James L Samuels

3 (b) If veteran, name war: World war II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mattie C Samuels

6 (c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.) March 8, 1908

8. AGE: Years 37 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace Titusville, Pa (Town, county, and state)

10. Usual Occupation Auto-Serviceman

11. Industry or business

FATHER
12. Name No Record
13. Birthplace " "

MOTHER
14. Maiden Name Martha Samuels
15. Birthplace Norfolk Va.

16 (a) Informant Recording Office
(b) Address Aberdeen Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Brooklyn, New York

18 (a) Funeral director Clarence E Belcher
(b) Address Havre de Grace, Md.

19 JAN 7 - 1946 Huntington Williams M.D. (Registered by)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1946 at 8 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute hemorrhagic pancreatitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarchic M.D. (Medical Examiner)
Date signed Jan 6, 1946

G36132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G36132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Powhatan Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Powhatan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah W. Heacock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George W. Heacock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1849

8. AGE: Years	Months	Days	If less than one day
96	3	16	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr. Yeadaker
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Kramer
15. Birthplace Germany

16 (a) Informant Mrs. M. Mayhaus
(b) Address Dogwood Rd., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller-Lamonaca
(b) Address 4510 Liberty Heights Ave.

19 JAN 8 1946 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1946 at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1945 to 1/4 1946 and that I last saw her alive on 1/4 1946.

Immediate cause of death	Duration
Pulmonary edema	6 hrs.
Due to Arteriosclerosis	?
Due to Senility	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reite M.D.
Address Garrison Blvd. & Windsor Ave. Date signed 1/6/46

G36133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis B McCann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Delia Lyons
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 25, 1882

8. AGE: Years 63 64 | Months 4 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Antique Dealer

FATHER
12. Name William V. McCann
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna E. Bien
15. Birthplace York, Pa.

16 (a) Informant Miss Clara E. McCann
(b) Address 1531 Park Ave.

17 (a) Burial (b) Date thereof Jan. 9, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Hollis Lamotte
(b) Address 1003 W. Baltimore St.

19 JAN 8 - 1946 (Registered by) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 January 1946 at 11:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If any external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury?

23. Signature William G Stafford, M.D.
(Medical Examiner)
Date signed 6 January 46

VS 151

G36134

CWK-88662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G36134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 6- 13
(e) Length of stay in Baltimore (yrs., mos., or days) 79- 6- 1- Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
James Arthur Harrison

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Annie E. Harrison
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) September 12, 1866 July 4-1867

8. AGE: Years	Months	Days	If less than one day
79 -78	5 -6	23 -1	hr. min.

9. Birthplace Maryland, Baltimore
(Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business

FATHER
12. Name James Harrison
13. Birthplace Howard County Maryland

MOTHER
14. Maiden Name Sarah Jane Crogler
15. Birthplace Govans, Baltimore Maryland

16 (a) Informant Mrs. Anna E. Harrison Baltimore City Hospitals
(b) Address 3206 Guilford Ave. 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jan. 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles Lamond
(b) Address 4510 Liberty Heights Ave.

19 (a) Filed JAN 8 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1946, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1944 to Jan. 5 1946, and that I last saw h. alive on Jan. 5 1946.

Immediate cause of death	Duration
Bronchial Pneumonia and uremia	?
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland
Address B.C.H. Date signed 1/5/46 M. D.

G36135

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 108

CERTIFICATE OF DEATH

G36135 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons Ave.
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12/31/45
(e) Length of stay in Baltimore (yrs., mos., or days) 1/5/46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Woodlawn [redacted] Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Inwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edith L. Kaiser

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John H. Kaiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Emory Zimmerman
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lidelia Baumont
15. Birthplace Baltimore Maryland

16 (a) Informant Mr. Emory Kaiser
(b) Address Inwood Rd., Woodlawn, Md.

17 (a) Burial (b) Date thereof Jan. 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miller L. Amoss
(b) Address 4010 Liberty Heights Ave.

JAN 8 - 1946 Turnington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1946, at 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1945 to Jan. 5 1946 and that I last saw her alive on 1/4/ 1946

Immediate cause of death Respiratory failure — Duration
Due to Lobar pneumonia
Due to
Other Conditions Arteriosclerosis
Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Curt Routt Jr.
Address 27 Ogres Date signed 1/5/46

VS 180

G36136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. G36136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 S Bernice Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 S. Bernice Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry V Alimo
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Claudia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11-1926

8. AGE: Years	Months	Days	If less than one day
19	5	26	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Rocco Alimo
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Alascia
15. Birthplace Baltimore Md

16 (a) Informant Theresa B. D'Anna
(b) Address 21 S. Bernice Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8-1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd.

18 (a) Funeral director Joseph Terrace Inc.
(b) Address 2413 Edgemont Ave

JAN 8 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-1946, at 89 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-1946 to 1-7-1946 and that I last saw h[illegible] alive on 1-6-1946

Immediate cause of death cerebral meningitis

Due to Grippe

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 3 days

?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. D'Amario M. D.
Address Medical Arts Bldg. Date signed

G36137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83Q

G36137 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) Hospital or institution Edgewood Nursing Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth M. Leitch

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Percy T. Leitch

6 (c) If alive, give age 87

7. Birth date of deceased (mo., day, yr.) July 13th 1867

8. AGE: Years	Months	Days	If less than one day
(78) 76	5	23	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Martin Keech
13. Birthplace Md.

MOTHER
14. Maiden Name Eva Martin
15. Birthplace Va.

16 (a) Informant Percy T. Leitch
(b) Address 716 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 8 - 1948 (Date rec'd by registrar) Huntington Wilkinson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6th 1946, at 8 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7th 1945 to Jan 6 1946 and that I last saw h ex alive on Jan 6 1946

Immediate cause of death
Paralysis
Due to
Due to
Other Conditions Cerebral Hallmorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration
18 months

study

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed Richardson MD
Address 112 W. 25th Date signed Jan 7 46 D.

G36138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G36138 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution: ar

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 42 24 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel E. Merritt

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1855

8. AGE: Years	Months	Days	If less than one day
90	10	19	hr. min.

9. Birthplace A. A. Co. Md
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Thomas H. Merritt
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Eliza A. Hawkins
15. Birthplace Md.

16 (a) Informant John R. Hutson
(b) Address 2821 Guilford Ave

17 (a) Burial (b) Date thereof 1/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul
Huntington Williams, Mgr.

19 (a) (Date rec'd by Local Reg.) JAN 8 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5th 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Jan 5 1946, and that I last saw her alive on Jan 4 1946.

Immediate cause of death Chronic myocarditis — Duration 3 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operation: Nil
of autopsy Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Nil
(b) Date of occurrence Nil at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Gordy M. D.
Address 510 Harford Rd Date signed 1-6-46

VS 150

G36139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G36139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4426 Forrestview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4426 Forrestview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philipp Heinz C. Egner

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband Bernhard Egner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1869

8. AGE: Years 76 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER 12. Name John M. Heun
13. Birthplace Germany

MOTHER 14. Maiden Name Elise (Unknown)
15. Birthplace

16 (a) Informant Milton D. Egner
(b) Address 3303 Beverly Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E Baltimore St

19 (a) JAN 8 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5th 1946; at 7:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Jan 5 1946 and that I last saw her alive on Jan 4 1946

Immediate cause of death: Ch. Myocarditis — Duration 3 years
Due to Arteriosclerosis
Ch. Nephritis
Due to Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Hardesty M. D.
Address 810 Belair Rd Date signed Jan 7/46

G36140 EWER ✓ 552 G36140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Granadas Bermuda (If outside city or town limits, write RURAL and give town)
(d) Street No. Pitts Bay Road. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Bermuda

3 (a) FULL NAME Cecil William B. Tower

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gwendoline R. Tower

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-99.

8. AGE: Years 46 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business Engineer

FATHER
12. Name Harry Cecil Tower
13. Birthplace England.

MOTHER
14. Maiden Name Mary Stickley
15. Birthplace England.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/9/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 JAN 8 1946 Huntington Williams
(Date rec'd by local registrar) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 6 1946, at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 30 1945, to 1 - 6 1946, and that I last saw h[illegible] alive on 1 - 6 1946.

Immediate cause of death: Anemia + cardiac failure — Duration: 6 wks

Due to: Multiple Myeloma — ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurel Dickson D
Address Johns Hopkins Hospital. Date signed 1/7/46

VS 150

(over)

36141 1/9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36141 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 N. Dallas St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Harding

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 187[illegible]

8. AGE: Years	Months	Days	If less than one day
72	9	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Annie Jenkins
(b) Address 101 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantley Ave.

JAN 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1946 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1945 to 1-3-1946 and that I last saw h[illegible] alive on 1-3-1946.

Immediate cause of death (Bronchio Pneumonia) Duration 23 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. R. Blake, M. D.
Address 327 N. Central Date signed 1-7-46

VS 150

G36142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G36142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital D.o.a.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 McElderry Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ESTHER STRAWDER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1927

8. AGE: Years	Months	Days	If less than one day
18			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name –
13. Birthplace

MOTHER
14. Maiden Name Mary Hinton
15. Birthplace md

16 (a) Informant Mary Hinton
(b) Address 1623 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Elroy Davidson
(b) Address 2000 Brentley ave

19 (a) JAN 8 - 1946 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1945, at 2:30A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Pneumohemothorax, bilateral
Due to Stab wounds of Chest,
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-31-45 at 2:15 A. M.
(b) Where did injury occur? Central and Madison Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stab wounds

23. Signature Benedict Shtarcher M.D.
(Medical Examiner.)
Date signed 12-31-45

G36143 ~~G36-97675~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos- 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 McMecken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oary or Orie Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10- 1900

8. AGE: Years	Months	Days	If less than one day
45	6	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Beauray Johnson (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Jarton (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan 10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Brooklyn Va
18 (a) Funeral director Brooks
(b) Address 1463 N. Carey
19 JAN 8 - 1946 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6- 1946, at 6.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1945, to 1-6- 1946, and that I last saw h im alive on 1-6- 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Cardiac failure	
Due to Hypertensive Cardiovascular Disease	
Coronary Thrombosis	
Due to	
Other Conditions Pulmonary infarcts	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: None at also

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigon M. D.
Address Baltimore City Hosp. Date signed 1-7-45

VS 150

G36144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G36144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Cumberland
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Lovejoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Willie Lovejoy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-92

8. AGE: Years 53 | Months 3 | Days 23 | If less than one day hr. min. 22

9. Birthplace Gadsden, Ala
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Willie Lovejoy
(b) Address 619 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8-1946 (month) (day) (year)
(c) Cemetery or crematory Church Cemetery
Location Sparks Md

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19. JAN 8 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1946 at 7½ P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1945 to 1-4 1946, and that I last saw her alive on 1-4 1946

	Duration
Immediate cause of death: Bronchopneumonia	36 hrs
Due to: cerebral hemorrhage, left hemiplegia	12 days
Due to: hypertensive cardio-renal disease	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Mosher St Date signed 1.6.46

36145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G36145

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Lawrence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1908

8. AGE: Years	Months	Days	If less than one day
37	1	28	hr. min.

9. Birthplace Eastern Shore Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wm Elzy
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Lucretia Douglas
15. Birthplace Eastern Shore Md.

16 (a) Informant Mrs Anna Lockard
(b) Address 1617 N. Fawcett St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

JAN 8 - 1946 (Date rec'd by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1946, at 6:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Conflagration
Due to Fourth Degree Burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-2- at 4:37 A.M.
(b) Where did injury occur? 1510 Lawrence St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration following - Explosion

23. Signature Howard J. Mackie M.D.
Medical Examiner.
Date signed 1-4-46

VS 151

636146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93C

636146 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution:
St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Bucks
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 250 Meadow Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA MAE SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife Charles L. Smith
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 6 1901

8. AGE: Years	Months	Days	If less than one day
44	6	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr Charles L. Smith
(b) Address 250 Meadow Rd.

17 (a) Burial (b) Date thereof 1/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Kleppinger Inc
(b) Address 715 Light St.

19 JAN 8 - 1946 (b) Huntington Williams, M.D.
(Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 6 1946 and that I last saw him alive on Jan 6 1946

Immediate cause of death Cardio-Respiratory Failure — Duration
Due to Uremia
Due to Rheumatic Cardio-Vascular Disease, Decompensated
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. Martin M. D.
Address St Joseph's Date signed Jan 6 1946

VS 150

36147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

Registered 36147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3822 Brooklyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3822 Brooklyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Foster Hagins

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth McCullough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1881

8. AGE: Years	Months	Days	If less than one day
54	11	9	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Civilian Worker
11. Industry or business U. S. Coast Guard

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Elizabeth Hagins
(b) Address 3822 Brooklyn Ave

17 (a) Burial (b) Date thereof 1/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glendale Haven
Location Annapolis Blvd

18 (a) Funeral director John F Fleming Inc
(b) Address 711 Light St.

JAN 8 - 1946
(Date rec'd by Registrar) (c) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4, 1946, at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946 to Jan 4 1946 and that I last saw deceased alive on Jan 4 1946

Immediate cause of death Asthmatic Bronchitis
Emphysema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address Med. Arts Bldg Date signed 1/7/46

(OVER)

G36148 To Be approved by Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G36148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Reynor Aves.
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Harlem Ave #17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie E. Whitaker

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Joseph W. Whitaker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1870

8. AGE: Years	Months	Days	If less than one day
75		24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Patterson
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Gillen
15. Birthplace Md

16 (a) Informant Lester Whitaker (Son)
(b) Address 1816 Harlem Ave #17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 1946 (Month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3107 W. North Ave.

JAN 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5-46 19 . at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1945 to 1-5 1946 and that I last saw h[illegible] alive on 1-5 1946

Immediate cause of death Cardiac FAILURE — Duration

Due to Concomitant of acl

Due to Fracture of left arm.

Other Conditions

(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental fall
(b) Date of occurrence 12-14 45 at 9 P.M.
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home
(Specify type of place) While at work?
(e) Means of injury Slipped & fell to floor

23. Signature Albert G. Herpmann M.D.
Address 715 Cullen Ave Date signed 1-5-46

VS 150

Amended Statistical M.D. X

G36149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G36149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Wayne Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Wayne Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Esther Young

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~XXX~~ John W. Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	6	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Emanuel Corbett
13. Birthplace England

MOTHER
14. Maiden Name Esther Watchman
15. Birthplace England

16 (a) Informant Miss Esther A. Young
(b) Address 3009 Wayne Ave.,

17 (a) Burial (b) Date thereof Jan. 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) JAN 8 1946 (b) Huntington Williams, M.D.
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1946, at 10.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1945 to Jan 4 1946 and that I last saw ~~her~~ alive on Jan 4 1946.

Immediate cause of death Coronary Occlusion — Duration 1 hr

Due to Hypertensive Cardio Vasc Disease — 15 yr

Due to Old Age

Other Conditions General Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J. Corbett M. D.
Address 4309 Liberty Heights Ave Date signed 1-9-46

G36.150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1192

G36.150

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (Westport)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2334 Annapolis Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Janice M Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/1945

8. AGE: Years	Months	Days	If less than one day
0	8	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Walter Norris
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alma Harvey
15. Birthplace Baltimore, Md.

16 (a) Informant Walter Norris
(b) Address 2334 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Huntington Williamsburg

JAN 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1946 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1945 to 1-6 1946 and that I last saw her alive on 1-6 1946

Immediate cause of death Hypertension

Due to Septicemia

Due to Acute catarrhal otitis media

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George R Callender M. D.
Address Univ Hosp. Date signed 1-6-46

89a

G36151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

936

G36151 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 E. Monument Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Kiwakowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
49	00		hr. min.

9. Birthplace Poland (Town, county, and State)
10. Usual Occupation Housework
11. Industry or business at Home

FATHER
12. Name Kaeus
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastend Ave

19 (a)..... (b)..... Registrar
(Date rec'd by)

JAN 8 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6, 1946 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan 5 1946 and that I last saw her alive on Jan 5 1946

Immediate cause of death Cerebral accident — Duration

Due to hypertensive cardio vascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Milton Gutsch M. D.
Address Johns Hopkins Hosp Date signed 1/5/46

G36152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G36152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 S Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Dziubek (Mrs)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Dziubek
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business At Home

FATHER
12. Name Robert Kulas
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant John Dziubek
(b) Address 419 S Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Czaszuski
(b) Address 1930 Eastern Ave

19 (a) (Date rec'd by reg.) (b) Registrar
JAN 8 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1946 at 1:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1943 to January 6 1946 and that I last saw h[illegible] alive on Jan 6 1946

Immediate cause of death HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE — Duration 6/1943
Due to
Due to
Other Conditions CHRONIC ARTHRITIS — ??

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. F. Varga
Address 209 [illegible] Date signed 1/7/46

36153

HEALTH DEPARTMENT—CITY OF BALTIMORE

G36153

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 271 S Atkinson St., 12 Ward) 1310 Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 3 mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Martha J. Guyton If U. S. Veteran specify WAR

(a) Residence: No. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Guyton

6. DATE OF BIRTH (month, day, year) Oct 10 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	2	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) York Co. Pa.

FATHER

13. NAME James S Parks

14. BIRTHPLACE (city or town) (State or country) Balto Co Md

MOTHER

15. MAIDEN NAME Morgant Hamilton

16. BIRTHPLACE (city or town) (State or country) York Co Pa

17. INFORMANT Mrs Robt Hohman

(Address) 271 Atkinson ave Balto Md

18. BURIAL, CREMATION, OR REMOVAL

Place Delta Pa Date Jan 11 1946

19. UNDERTAKER Herbert P Hopkins

(Address) Delta Pa

20. JAN 8 - 1946 Huntingtown Williamsport Md

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 8 1946

22. I HEREBY CERTIFY, That I attended deceased from Oct 13 1945 to Jan 8 - 1946

I last saw her alive on Jan 8 1946 Death is said to have occurred on the date stated above, at 12 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	many y
Arteriosclerosis	
Chronic Nephritis	

Other contributory causes (if any) were:

Was an operation performed? No Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) R A Richardson M.D.

(Address) 11210. 20th St

36154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered 36154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Hom + Hospital
(d) Length of stay in hospital or inst. (yrs., ~~mos., or days~~)
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Hom + Hosp (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estelle Ingram Constable

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John S. Court.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Resident of Home
11. Industry or business

FATHER
12. Name Wm W. Stephens
13. Birthplace Md.

MOTHER
14. Maiden Name Margaretta Beal
15. Birthplace Md.

16 (a) Informant Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 10/46 (month) (day) (year)
(c) Cemetery or crematory Old St Pauls Cem
Location Chestertown Md.

18 (a) Funeral director John O. Mitchell Estate
(b) Address 1900 Eutaw Place

19 (a) (b)
(Registered by registrar) Registrar

JAN 8 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1946 at 6 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1945 to 1-6-1946, and that I last saw h in alive on 1-6-1946

Immediate cause of death Acute Pulmonary Edema — Duration

Due to Hypertensive arteriosclerotic C.V.D.

Due to

Other Conditions Suffering a cerebral Hemorrhage?
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Hom + Hosp Date signed 1-6-46

Huntington Williams, M.D.

G361555

TM. 98340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G361555 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10th 1913

8. AGE: Years 32 | Months 3 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Monokey
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Holsten
(b) Address 91 E. Lanvale Hill Ave.

19 (a) ... (b) ...
(Date rec'd by registrar) JAN 8 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6th 1946 19..., at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6th 1946 19... to Jan. 6 19 46 and that I last saw him alive on Jan. 6th 19 46.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to:

Due to:

Other Conditions: Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 1/7/46

G36156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G36156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 N.Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) Md.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N.Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William C.Rollison

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Etta Rollison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.1,1870

8. AGE: Years	Months	Days	If less than one day
75	10	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Wm.L.Rollison
(b) Address 604 N.Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.7/46 (month) (day) (year)
(c) Cemetery or crematory Mt.Olivet Cem.
Location Balto. Md.

18 (a) Funeral director Philip A Hering Sons
(b) Address 2024 Orleans St.

19 Jan 6 46 (Date rec'd by Registrar) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan.5th. 1946 at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1 1946 to JAN 5 1946 and that I last saw h[illegible] alive on Jan 5 1946

Immediate cause of death ARTERIOSCLEROSIS — Duration 10 YRS

Due to HYPERTENSION — 3 YRS

Due to

Other Conditions CEREBRAL HEMORRHAGE — 5 DAYS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F Carrington M.D.
Address 3318 McElderry St. Date signed 1-6-46

VS 150

G36157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 N.Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N.Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances O.Lehmann

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
--	214-01-2773	Female	White	Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm.Lehmann
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Hulse
15. Birthplace Germany

16 (a) Informant Miss Fredericka Lehmann
(b) Address 611 N.Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) JAN 8 1946 (Date rec'd by registrar) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5th. 1946 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1945 to Jan 5 1946.
and that I last saw h[illegible] alive on Jan 5 1946

Immediate cause of death	Duration
Cardiovascular	7 days
Due to Hypertension	
Due to Fibroid	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 1/7/46

VS 150

G36158 — BALTIMORE CITY HEALTH DEPARTMENT — G36158 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Green
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 11 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Bal.
(c) City or town: Whitehall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: William Walton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	S

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1931

8. AGE: Years	Months	Days	If less than one day
15			hr. min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual Occupation: Student
11. Industry or business:

FATHER
12. Name: Robert Walton
13. Birthplace: Md.

MOTHER
14. Maiden Name: Adele Buchanan
15. Birthplace: Md.

16 (a) Informant: Robt. Walton
(b) Address: White Hall Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 10th 1946 (month) (day) (year)
(c) Cemetery or crematory: St. James
Location: Federal Hill Harford Rd

18 (a) Funeral director: Martin & Kent
(b) Address: Lanvale & Eutaw

19 (a) JAN 8 - 1946 (Date received by registrar) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-8 1946 at 1:04 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1945 to 1-8 1946, and that I last saw her alive on 1-8 1946.

Immediate cause of death	Duration
Cerebral abscess	
Due to: Tuberculous Meningitis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: C. L. Burton M. D.
Address: Univ. Hosp. Date signed: 1-8-

VS 150

6159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312 Registered No. G36159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 Penna ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-8819

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-1888

8. AGE: Years 57 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Nettie Jones
(b) Address 1912 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-46 (month) (day) (year)
(c) Cemetery or crematory Arlington Memo Park
Location Arbutus Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) JAN 8 1946 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946 at 3:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to June 7 1946 and that I last saw ... alive on Jan 7 1946

Immediate cause of death Cerebral Hemorrhage — Duration April 1945

Due to Hypertension
Cardio-vascular

Due to Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Enslen M. D.
Address 803 a Fremont Date signed

VS 150

6160

CEK- 98130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G36160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Division Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hudson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
73 ?	?	?	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Mark Hudson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Adeline ?
15. Birthplace North Carolina

16. (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1-8-46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenlawn Mem'l
Location Balto. Co.

18 (a) Funeral director Mayo & Holland
(b) Address 1638 Druid Hill Ave.

JAN 8 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH January 5 1946 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1945 to Jan. 5 1946, and that I last saw h im alive on Jan. 5 1946

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Lane

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr.
Address Balt. City Hosp. Date signed 1/6/46

G36161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G36161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Division
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jacobs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Raymond Jacobs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE 62 Years 6 Months Days If less than one day hr. min.

9. Birthplace West Moreland Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Felix King
13. Birthplace Va

MOTHER
14. Maiden Name Sarah —
15. Birthplace Va

16 (a) Informant
(b) Address 448 Watts Lt.

17 (a) Burial (b) Date thereof 1/8/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Fredericksburg
Location Fredericksburg. Va.

18 (a) Funeral director Lee H Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 8 - 1946
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6- 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1945, to 1-6 1946, and that I last saw h alive on 1-5 1946

Immediate cause of death Chronic Hypertension Cardio Renal

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Lyerly M. D.
Address Fredericksburg Va Date signed 1/7/46

G36162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 30 D

Registered No. G36162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N. Carey Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Norman Leonard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3 1899

8. AGE: Years 46 | Months 4 | Days 2 | If less than one day .....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Leonard
13. Birthplace Md

MOTHER
14. Maiden Name Deborah Legree
15. Birthplace Md

16 (a) Informant Mildred Gilliga

(b) Address 814 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Md

18 (a) Funeral director Geo. B. Kelson

(b) Address 1303 Preston St

19 (a) (Date received by registrar) JAN 8 1946 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5- 1946, at 10:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema.

Due to Congestive Cardiac failure

Other Conditions Syphilitic aortitis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at .....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-7-46

G36163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Rolle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1871

8. AGE: Years	Months	Days	If less than one day
74	10	21	hr. min.

9. Birthplace Baltimore Md. USA
(Town, county, and state)

10. Usual Occupation housekeeper

11. Industry or business

FATHER
12. Name James Nelgrieb
13. Birthplace ? ?

MOTHER
14. Maiden Name Annie Steinbach
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St City

17 (a) Burial (b) Date thereof Jan 9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director E. Worthington Evans
(b) Address 1100 Eutaw St

19 (a) 1/8/46 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Jan 6 1946, and that I last saw her alive on Jan 6 1946.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arterio Sclerosis	6 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Av Date signed 1/6/46

VS 150

G36164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36164 Registered No.

TN:

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19- 7-month & 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 Westphal St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Zeller

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles Zeller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5th 1863

8. AGE: Years	Months	Days	If less than one day
82	9	1	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Wm. Mathais
13. Birthplace Pa.

MOTHER
14. Maiden Name Pauline
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave [Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto

18 (a) Funeral director C. Howard Evans
(b) Address 440 S Charles St

19 (a) 1/8/46 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6th 1946 19 , at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28th 19 26 to Jan. 6 19 46 and that I last saw her alive on Jan. 6th 19 46

Immediate cause of death Bronchopneumonia?

Duration

Due to

Due to

Other Conditions Arteriosclerosis, generalized.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Moreland M. D.
Address B.C.H. Date signed 1/7/46

VS 150

X

G36165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G36165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 3606 Fifth St
(c) Hospital or institution:
25
(d) Length of stay in hospital or inst. (yrs., mos., or days).
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Fifth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Wainwright

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Laura V Wainwright | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1878

8. AGE: Years 67 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Solomons Island
(Town, county, and state)

10. Usual Occupation Colored Lawyer

11. Industry or business Self employed

FATHER
12. Name Benjy Wainwright
13. Birthplace Calvert Co

MOTHER
14. Maiden Name Elizabeth Daugherty
15. Birthplace Calvert Co

16 (a) Informant Laura V Wainwright
(b) Address 3016 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 1946 (month) (day) (year)

(c) Cemetery or crematory Mt O'Rest
Location Balto

18 (a) Funeral director C. Howard Evans
(b) Address 1400 N Charles St

19 (a) 1/8/46 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Jan 1946. and that I last saw h[illegible] alive on Jan 6 1946.

Immediate cause of death carcinoma prostate — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. H. Kerby, MD M. D.
Address 302 Patterson Av Date signed 1/7/46

VS 150

G36166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36166 Registered No. 1240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 13 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Eleanor M. Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife James C. Brewer
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) July 30, 1898

8. AGE: Years	Months	Days	If less than one day
47 48	5	7	---hr. --min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name William Mallonee
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Eleanor Pierce
15. Birthplace Baltimore, Maryland

16 (a) Informant James C. Brewer
(b) Address 605 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 JAN 8 - 1946 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1946, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism;
Fatty degeneration of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a). Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Faehler M.D.
Medical Examiner.
Date signed Jan 7 1946

Huntington Williams, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 S. Grundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin McGreevy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dessie J. Burkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28-1895

8. AGE: Years	Months	Days	If less than one day
49	4	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Switch Tender
11. Industry or business Penna R.R.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory H. Mathias O'Donnell Jr
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) JAN 8 - 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4- 1946 at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4- 1946 to 1-4- 1946, and that I last saw him alive on 1-4- 1946.

Immediate cause of death Cerebral embolism due to

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret McDavis M. D.
Address B Ext Date signed 1-6-46

VS 150

636168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

Registered No. 636168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Columbus Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Minkin

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	212-26-7934

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1886

8. AGE: Years	Months	Days	If less than one day
59	7	13	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Sales woman
11. Industry or business Silbers Bakery

FATHER — 12. Name	Isidore Robinson
FATHER — 13. Birthplace	Russia
MOTHER — 14. Maiden Name	Sophie ?
MOTHER — 15. Birthplace	Russia

16 (a) Informant Julius Robinson
(b) Address 3768 Columbus Dr
17 (a) Burial (b) Date thereof 1-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Wabash & Mitchell Rd.
18 (a) Funeral director Sol Levinson Bro
(b) Address 1124 W North ave
19 (a) (b)

JAN 8 1946 Huntington, W. Va.
Registrar
Vs 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-, 1946, at 11 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Ruptured Liver & Kidney

Due to

Other Conditions Fractured ribs, fractured long bones, Contusions etc
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 15/11
(a) Date of injury 1-7-46 at 6.50 P. M.
(b) Where did injury occur? Theton & Liberty Heights Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by auto.

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 1-8-46

G36169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32a

G36169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 05 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLARD A GODROW

3 (b) If veteran, name war W | 3 (c) Social Security Account No. 215-01-9931

4. Sex Male | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16 1909

8. AGE: Years 36 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Barton Vt (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER 12. Name George Godrow
13. Birthplace Vermont

MOTHER 14. Maiden Name Stella Jenks
15. Birthplace Vermont

16 (a) Informant Ida Godrow
(b) Address 11 W Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 8 46 (month) (day) (year)
(c) Cemetery or crematory Shrewsbury
Location Shrewsbury Penn

18 (a) Funeral director Wilson Lodge
(b) Address 1217 E Fayette St

1946 1 8 – 1946 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1946, to 1/7 1946 and that I last saw him alive on 1/7 1946

Immediate cause of death Resp & Embol Failure — Duration

Due to Myocarditis Diagnosed Clinically

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James G. Bo M.D.
Address Redwood & Green Sts. Date signed 1-7-46

VS 150

G36170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G36170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution:
Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Windsor Court Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Dwight S Hartlove

3 (b) If veteran, name war: Spanish

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Abbie Mecham Hartlove
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1875

8. AGE: Years	Months	Days	If less than one day
70	9	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retirad Lumber Exporter
11. Industry or business Self

FATHER
12. Name John W. Hartlove
13. Birthplace Baltimofe, Md.

MOTHER
14. Maiden Name Blanche Marguette
15. Birthplace Balto., Md

16 (a) Informant Mrs. Abbie M. Hartlove
(b) Address Windsor Court Apts., Balto.16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams M.D.
JAN 8 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1946 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1946 to 1-7 1946 and that I last saw him alive on 1-7 1946

Immediate cause of death: Internal Hemorrhage — Duration

Due to ? Ulcer of SC tract

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank E. Crouse M.D.
Address Linden & Madison Date signed 1-7-46
M. D.
Emergency Funeral Hospital

G36171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Mansfield General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4249 Wickford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius A. Burkhardt

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Edith C. Burkhardt
6 (c) If alive, give age 1873 years

7. Birth date of deceased (mo., day, yr.) July 22, ~~1872~~

8. AGE: Years	Months	Days	If less than one day
~~73~~ 72	5	15	hr. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)
10. Usual Occupation Certifying Officer
11. Industry or business U. S. Federal Reserve System

FATHER
12. Name Adam E. Burkhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Emma A. Erkenbrecher
15. Birthplace Cincinnati, Ohio

16 (a) Informant Mrs. Roy Palmer
(b) Address 4249 Wickford, Rd.

17 (a) Removal (b) Date thereof 1/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Grove Cem.
Location Cincinnati, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received JAN 8 1946 Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1946, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1946, to 1/7 1946, and that I last saw him alive on 1/7 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Arteriosclerotic C.V. Disease with Pulmonary Edema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morton E. Strobel M. D.
Address Md. Gen. Hospital Date signed 1/7/46

(over)

G361772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Windsor Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Windsor Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Davis

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1856

8. AGE: Years 89 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Howard County Maryland (Town, county, and state)
10. Usual Occupation housework
11. Industry or business none home

FATHER
12. Name William Davis
13. Birthplace Howard County Md

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Harford County Md.

16 (a) Informant Mrs Mary Forrester
(b) Address 2819 Windsor Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Ellicott City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1946 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1945 to Jan 7 1946 and that I last saw h[illegible] alive on Jan 3 1946.

Immediate cause of death: Chronic Myocardial Degeneration — Duration: 7 yrs
Due to:
Due to:
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation no operation
Major findings of operation:
of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua H. Armacost M. D.
Address 6419 Windsor Mill Rd Date signed Jan 7 1946

VS 150

JAN 8 - 1946 Huntington Williams M.D.

Baltimore-7

G36173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 B

G36173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6912 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B Wainwright

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	213-07-7407

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Annabel Wainwright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1906

8. AGE: Years	Months	Days	If less than one day
40	0	1	hr. min.

9. Birthplace Blairsville, Pa.
(Town, county, and state)
10. Usual Occupation Electrical Shift Foreman
11. Industry or business Beth. Steel Co.

FATHER
12. Name Charles S. Wainwright
13. Birthplace Blairsville, Pa.

MOTHER
14. Maiden Name Alice Repine
15. Birthplace Blairsville, Pa.

16 (a) Informant Mr. W. C. Wilkinson
(b) Address 3801 Cedardale Rd.

17 (a) Burial (b) Date thereof 1/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 8

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1946, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 AM 1-6 1946 to 3:20 P 1-6 1946 and that I last saw h/m alive on 3 PM 1-6 1946

	Duration
Immediate cause of death: Ether Anesthetic Death	Instantaneous
Due to: —	
Due to: —	
Other Conditions: Perinectal Abscess	4 days

(Include pregnancy within 3 months of death)
Date of operation 1-6-46
Major findings of operation: Large Perinectal Abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Anesthetic Accident
(b) Date of occurrence 1-6-46 at 3:20 P M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Church Home & Hosp. While at work? No
(Specify type of place)
(e) Means of injury Ether Anesthesia

23. Signature Robert D Dodd M. D.
Address Church Home & Hosp Date signed 1-6-46

Hospital Form Williamsport, Pa.
For B. C. J. Tubman, by Thomas Williamsport, M. D.

G36174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G36174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Lozuk

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-1751

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dorothy

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) about 1895

8. AGE: Years 50 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Paul Jones + Co

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Dorothy Lozuk

(b) Address 2013 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-46 (month) (day) (year)

(c) Cemetery or crematory ST. STANISLAUS

Location Baltimore Md

18 (a) Funeral director George A Weber

(b) Address 745 S Ann st

19 (a) (Date of death) (b) Hunting for Millsboro Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1946 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxia due to strangulation

Due to

Other Conditions Dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1/6/46 at 5:00 P.M.

(b) Where did injury occur? 3rd Floor 2013 E Lombard St

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No.

(d) Means of injury Hanged self with belt from back post

23. Signature C. P. Turkinski M.D. Medical Examiner.

Date signed 1/7/46

G36175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Lanvale Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 W Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H Bailey
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21856

8. AGE: Years	Months	Days	If less than one day
89	9	2	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Henry Bailey
13. Birthplace Va

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Va

16 (a) Informant Thomas Bailey
(b) Address 1315 Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 101 W Monument St

19 (a) Date received (Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946, at 1-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945 to Jan 7 1946, and that I last saw h[illegible] alive on Jan 7 1946

Immediate cause of death Hypostatic pneumonia — Duration 10 days
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Redden
Address 426 N. Johns St Date signed 1/8/46

VS 150

G36176 BALTIMORE CITY HEALTH DEPARTMENT G36176

CERTIFICATE OF DEATH 484 Registered No.

1. PLACE OF DEATH: DOA
(a) Baltimore City, Maryland
(b) Street address 247 N. Carlton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 247 N. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1902

8. AGE: Years	Months	Days	If less than one day
43	3	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Neal
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sarah Snowden
15. Birthplace Baltimore, Md.

16 (a) Informant Joseph Neal (uncle)
(b) Address 109 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie P. Williams
(b) Address 322 N. Schroeder St.
JAN 8 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1946 at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to be death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sabinski M.D.
Medical Examiner.
Date signed 1/7/46

VS 151

G36177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V179X

Registered No. G36177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Myrtle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Allan Barnes (Hill)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1943

8. AGE: Years 2 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H. Hill
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Barnes.
15. Birthplace Baltimore, Md.

16 (a) Informant Martha Barnes Hill
(b) Address 205 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9, 46 (month) (day) (year)
(c) Cemetery or crematory Int. Zion
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 322 N. Schroeder St.

19 JAN 8 - 1946 (Date rec'd by registrar) (b) Huntington Williamsburg Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1945, at 9 55P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aspiration of stomach contents; atelectasis of both lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4/2

(a) Date of injury Jan. 4, 1945 M.
(b) Where did injury occur? 205 Myrtle Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Overlayed Ben Gray M.D.

23. Signature Benedict Skaterelic Medical Examiner.
Date signed 1-5-45

VS 151

G36178 G36178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Booker St. Gilmore Homes
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Booker St. Gilmore Homes
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah Eaton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Wd

6 (b) Name of husband or wife Joseph Eaton
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1906

8. AGE: Years	Months	Days	If less than one day
39	7	18	hr. min.

9. Birthplace Gloucester Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Banks
13. Birthplace Gloucester Va

MOTHER
14. Maiden Name Nancy Page
15. Birthplace Gloucester, Va

16 (a) Informant Jane Joseph Eaton
(b) Address 1601 Booker St

17 (a) Burial (b) Date thereof Jan 8 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 3222 N. Schroeder St.

19 (a) JAN 8 - 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1946, at 10½ P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1945, to 1-4 1946, and that I last saw h[illegible] alive on 1-4 1946.

Immediate cause of death	Duration
Cardio Vascular - Renal Disease	4 years
Due to —	
Due to —	
Other Conditions La Grippe	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Hughes M. D.
Address 825 N. Fremont Ave Date signed 1-8-46

VS 3

G36179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1577

G36179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 N. Pulaski St. 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boy Buckner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Saul J. Buckner
13. Birthplace Balto Md

MOTHER: 14. Maiden Name Eleanor R. Seligman
15. Birthplace Balto Md

16 (a) Informant Father Saul J. Buckner
(b) Address 1500 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (month) (day) (year)

(c) Cemetery or crematory Helyn Evergreen
Location Belair & Loudon Sts

18 (a) Funeral director Lattz Sons Inc
(b) Address 1830 E. Baltimore St.

1-8-1946 (b)
(Date rec'd) (Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1946, at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 19 45 to 1/7 19 46
and that I last saw h alive on 1/7 1946

Immediate cause of death Congenital Atresia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Yes

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 103 E. North Ave Date signed 1-8-46

G36180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93D

G36180 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2232 Hennemann Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Hennemann Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Sebree

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1881

8. AGE: Years 64 | Months - | Days 13 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George W.
13. Birthplace Lancaster Va

MOTHER
14. Maiden Name —
15. Birthplace Ireland

16 (a) Informant John W. Sebree
(b) Address 2232 Hennemann Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Jan 11th 1946 (month) (day) (year)
(c) Cemetery or crematory New Loathendal
Location Edmondson Ave

18 (a) Funeral director Leo S. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 JAN 8 - 1946 (Date received by registrar) (Signature of registrar) Huntington Williams M.D.

VS 150 Dr Grossman

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7th 1946, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to 1/7 1946 and that I last saw h[illegible] alive on 1/6 1946.

Immediate cause of death	Duration
Arteriosclerotic R.V. Disease	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Karl Grossman

Address 1212 N. Patterson Date signed 1/8/46

J. Karl Grossman

G36181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Dft
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Theodore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	29	hr. min.

9. Birthplace Va. Gloucester Co
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Major Boyd
13. Birthplace Va.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Va

16 (a) Informant Sylvester E. Holland
(b) Address 806 N. Bond St

17 (a) Burial (b) Date thereof Jan 9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location G. A.; County Md

18 (a) Funeral director Mrs Roberta E. Elliott
(b) Address 1129 N. Carolina St

19 (a) [illegible] Huntington Williams
(Date received by local registrar)

JAN 8 1946

S 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1946, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Sabrinski M.D.
Medical Examiner.
Date signed 1/5/46

G36182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1111B

G36182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Mickey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race black | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1910

8. AGE: Years 35 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Leonardtown, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ben Mason
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Gun
15. Birthplace Md.

16 (a) Informant Irvin Height
(b) Address JONES HOPKINS HOSPITAL 1739 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Leon
Location Anne Arundel County Md.

18 (a) Funeral director Mrs. John Elliott Baughman
(b) Address 1127 N. Caroline St.

19 1946 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 - 1946 at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-1946 to 1-5-1946 and that I last saw him alive on 1-5-1946.

Immediate cause of death: Acute pulmonary Edema, cause not determined — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip R. Nimuth
Address Johns Hopkins Hospital
Jan 45
Howard J. Mueller, M.D.

G36183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W
(b) Street address 416 Hamietta St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 W. Hamietta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1895

8. AGE: Years	Months	Days	If less than one day
50	5	0	hr. min.

9. Birthplace King George County Va (Town, County, and state)

10. Usual Occupation Head Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs C. Smith
(b) Address 416 Hamietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Girdy
(b) Address 4692 Mount Street

19. (a) JAN 8 1946 (Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 at 8A M

21. I certify that I took charge of the remains described above, held an Insp. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarczak M.D. Medical Examiner.
Date signed Jan 6, 1946

Huntington Williams M.D.

G36184 G36184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Martin (Markunas)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1880

8. AGE: Years	Months	Days	If less than one day
65	7		hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Andrew Lackwith
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Danuke
15. Birthplace Poland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location

18 (a) Funeral director Peter Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) 1946 Filed by registrar Arlington Williams, M.D. Registrar

8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946, at 8-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Jan 6 1946, and that I last saw h e alive on Jan 6 1946.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Acute Bronchitis	6 days
Due to	
Other Conditions Chronic Myocarditis	3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E Northern Date signed 1/7/46

X

G36185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36185 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Helton Street
(c) Hospital or institution: Ashburton Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5802 York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ashburn Wilson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife W. H. T. Wilson
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Feb 12 1864

8. AGE: Years	Months	Days	If less than one day
81	10	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name John W. Kirkman
13. Birthplace Maryland

MOTHER
14. Maiden Name Sallie Emmart –
15. Birthplace Maryland

16 (a) Informant J. W. Stiffe – (nephew)
(b) Address 2723 Eyleburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Sherwood Magruder
(b) Address 1085 Park Ave.

19 (a) Registrar's signature JAN 8 1946 (b) Registered Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Jan 7 1946 and that I last saw h[illegible] alive on Jan 5 1946

Immediate cause of death	Duration
Myocardial degeneration & insufficiency	
Arteriosclerotic type	General
Due to Renal disease with	Yrs.
congestive failure.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Mitchell M. D.
Address 2901 Edmondson Date signed Jan 8 1946

X

G36186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G36186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 - Mansse Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 - Mansse Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sheppard.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1878

8. AGE: Years	Months	Days	If less than one day
67	1		hr. min.

9. Birthplace Macon, Ga.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Howard Sheppard
13. Birthplace Ga.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Carrie Sheppard
(b) Address 419 - Mansse Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Holstead
(b) Address 915 - Edmond Hill Ave

19 (a) Filed JAN 8 1946 (b) Signature of local registrar Hunter for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6- 19 46 at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1945 to Jan 6 1946 and that I last saw h[im] alive on Jan 5 1946

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Pelletier
815 Hamilton Ave Date signed M. 1/8/46 D.

VS 150

36187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 36187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Md.
(b) Street address.....
(c) Hospital or institution: Doctors Hospital 876 Washington Blvd.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Hooper St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Hampton.

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a). Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Hampton
6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) 1-3-46

8. AGE: Years: 10 hours | Months | Days | If less than one day: 10 hr. ..... min.

9. Birthplace Doctors Hospital (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Unknown
13. Birthplace.....

MOTHER
14. Maiden Name Mary Atkinson
15. Birthplace Wheat. W. Va.

16 (a) Informant Doctors Hospital
(b) Address ~~1304 Hooper St.~~ Balto 23

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Johns Hopkins Medical School JAN 8 1946

18 (a) Funeral director Commissioner of Health
(b) Address.....

JAN 8 1946 Thurlow Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 19 46 at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from.....19....., to.....19.....
and that I last saw h..... alive on.....19.....

Immediate cause of death: Congenital Heart Disease — Duration

Due to Prematurity

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Louis J. Goss M.D.
Address 816 Wilmot Rd Date signed 1/7/46

3209

36188 AB-9063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-yrs-10 mos-23days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Charles (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? 1865?

8. AGE: Years 80 ? | Months 6? | Days ? | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Wesley Walker
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia Dever
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 8 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 8 1946 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27- 1945, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4- 1931, to Dec. 27 1945 and that I last saw h. er alive on Dec. 27- 1945

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 1-5-46

VS 150

13208

6189

AB- 97857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G36189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Seitz or Sietz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Mathilda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30- 1865

8. AGE: Years	Months	Days	If less than one day
80	5	25	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Matthew
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 8 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 8 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Dec. 25- 1945, at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1945, to 12-25 1945, and that I last saw h. in alive on 12-25- 1945

Immediate cause of death	Duration
? Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 1-5-45

3207

X

6190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 D

Registered No. G36190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 236 E. Montgomery Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pugh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1946

8. AGE: Years	Months	Days	If less than one day?
			hr. 3 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Pugh
13. Birthplace

MOTHER
14. Maiden Name Anna M. Bridge
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 8 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 8 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1946, at 9:05AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1946, to January 1 1946, and that I last saw him alive on January 1 1946.

Immediate cause of death: encephalocele — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Vosburgh M.D.
Address Johns Hopkins Hospital Date signed 1-3-46

3210

G36191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120

G36191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Tangier (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marshall, Homer Louis

3 (b) If veteran, name war

3 (c) Social Security Account No. 223-24-6846

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret Parks Marshall
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1910

8. AGE: Years	Months	Days	If less than one day
35	5	0	hr. min.

9. Birthplace Tangier, Va. (Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business

FATHER
12. Name Milton Marshall
13. Birthplace Tangier, Va.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Tangier, Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1946 (month) (day) (year)
(c) Cemetery or crematory Tangier Island
Location Tangier Island, Md.

18 (a) Funeral director W. P. Lawson
(b) Address Crisfield Md

19 (a) 8 1946 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1946, at 7:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1945 to Jan. 8 1946 and that I last saw him alive on Jan. 8 1946

Immediate cause of death	Duration
Acute hemorrhagic nephritis with uremia	27 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 1/8/46
US Marine Hospital, Balto, Md.

11-36154

G36192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1799

G36192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Hymon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years: 22 | Months | Days | If less than one day: hr. min.

9. Birthplace Cleveland Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Joseph Griff
13. Birthplace Va.

MOTHER
14. Maiden Name Mary ann?
15. Birthplace Va.

16 (a) Informant George Hymon
(b) Address 520 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6-1946 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1945 to Jan 6 1946 and that I last saw h[illegible] alive on Jan 6 1946

Immediate cause of death Bilateral Empyema, Lobular Pneumonia, Dehydration, malnutrition

Due to Complete Esophageal Obstruction

Due to Ingestion of Lye.

Other Conditions Perforated Esophagus and mediastinitis.
(Include pregnancy within 3 months of death)

Date of operation Jan 2, 1946

Major findings of operation: Gastrostomy

of autopsy: See above

Duration: Since Nov 27 1945

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 17/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence November 27 1945 at 3 M
(c) Where did injury occur? 525 W. Biddle St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Ingestion of Lye.

23. Signature Reece R. Brooks, Jr. M. D.
Address University Hospital Date signed 1-7-46

Howard J. Henderson, M.D.

JAN 8 - 1946

G36193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G36193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 Spaulding Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Spaulding Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Cornelius Spedden

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 245-07-8717

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Ellen Spedden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 78 | Months 9 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Insurance Salesman

11. Industry or business Insurance Agency

FATHER 12. Name John F. Spedden

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Sallie Cornelius

15. Birthplace Towson-Balto. Co., Md.

16 (a) Informant Mary Ellen Spedden

(b) Address 3708 Spaulding Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md.

18 (a) Funeral director Roger Brown

(b) Address 300 E. Fayette St.

19 (a) JAN 8 1946 Washington Witherington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1946 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Jan. 6 1946 and that I last saw him alive on Dec. 28 1945.

Immediate cause of death	Duration
Coronary Occlusion	2 minute
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Grubbs

Address 2220 Garrison Blvd. Date signed M 1 D 8/46

G36194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 Strickland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 320 Strickland St
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Balto Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fredricka Milenhausen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Dead

6 (c) If married, widowed, or divorced, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1861

8. AGE: Years 84 | Months 5 | Days 7 | If less than one day 24 hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name Fred Sacher

13. Birthplace Germany

MOTHER 14. Maiden Name Not Known

15. Birthplace Germany

16 (a) Informant A. Sachnas

(b) Address 320 Strickland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (mo.) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Frederick Ave

18 (a) Funeral director Geo Leimbach

(b) Address 525 N. Eutaw St

1/9/46 (Date rec'd by registrar) Huntington Williams Md

B-VS 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 at 130 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 6 1946 and that I last saw h.er alive on Jan 6 1946

Immediate cause of death Myocarditis Chronic Repeated

Due to Arteriosclerosis Marked

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 days
7.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Blanchard M. D.

Address 332 Druid Hill Ave Date signed 1/6/46

6195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1862

Registered No. G36195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: N. Fayette St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 416 Patapsco Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Christina Helmstetter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/24/885

8. AGE: Years	Months	Days	If less than one day
60	7	6	3 hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name William Helmstetter
13. Birthplace Germany

MOTHER
14. Maiden Name Ezza Rheinhardt
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore, Maryland

18 (a) Funeral director Jos. L. Baker & Son
(b) Address 1318 Light St.

JAN 9 - 1946 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6/1946, at 1:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24/1946 to 1/6/1946, and that I last saw h.e.r. alive on 1/6/1946.

Immediate cause of death: Ven. I Carcinoma (Sigmoid)
Due to
Due to
Other Conditions: Pernicious Anemia
Op. Ap. Rd. Perforated Ulcer
(Include pregnancy within 3 months of death)
Date of operation 7/20/45
Major findings of operations: Fracture of Head Femur.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-24-45 at 3 M
(c) Where did injury occur? 416 Patapsco Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify) While at work? No
(e) Means of injury Slipped and fell on a floor

23. Signature Howard J. Masters, M.D.
Address Bon Secours Hosp. Date signed 1/6/46

Howard J. Masters, M. D.

36196 BALTIMORE CITY HEALTH DEPARTMENT G36196

CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 Jefferson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Dunkirk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ludley M. Bright

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-1091

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Emilie C. Bright

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 11 1901

8. AGE: Years	Months	Days	If less than one day
44	6	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Administrative Officer

11. Industry or business Camp Holabird

FATHER 12. Name Edward Bright

13. Birthplace Md

MOTHER 14. Maiden Name Anna Holidayoke

15. Birthplace Md

16 (a) Informant Emilie Bright

(b) Address 723 Dunkirk Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 (month) (day) (year)

(c) Cemetery or crematory Maryland Memorial Park

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004 E. Orleans St

JAN 9 - 1946 (Date received by Registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942 to Nov 1945; and that I last saw him alive on Nov 12 1945.

Immediate cause of death: Coronary occlusion — Duration: 5-7 yrs

Due to: Sclerosis art

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor Richards M. D.

Address 321 Dunkirk Date signed 1-7-46

Med Exam Case 372450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G36197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 3107 Sharon Terr
(If rural give location)
(e) Citizen of foreign country? Shannon (Yes or No)
If yes, name country

3 (a) FULL NAME August Mueller — To be Approved by Medical Examiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Leona Mueller
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1881

8. AGE: Years	Months	Days	If less than one day
64	2	5	hr. min.

9. Birthplace Baden (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Building Steel

FATHER
12. Name John C Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Bopp
15. Birthplace Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan 9
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Rural

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans

JAN 9 - 1946 (b) Huntington Wil... 11
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5- 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5- 1946 to 1-5- 1946 and that I last saw h[illegible] alive on 1-5- 1946.

Immediate cause of death	Duration
Heart Failure	6 hrs
Due to Myocardial Infarction	12 hrs
Due to Arteriosclerotic Heart Disease	? 10 yrs
Other Conditions Lacerations of face 2 simple rib fractures (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: as stated above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide MV accident 9 hrs
(b) Date of occurrence 6 00 AM - 1/5/46 at M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) NTM While at work? Was NTM.
(e) Means of injury Chest contusion auto into an electric pole NTM.
23. Signature Laurence Dinsmore MD
Address Johns Hopkins Hospital Date signed 1/6/46

Howard J. Warren, M.D.

36198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. 36198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 S. Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. Potomac St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Schmidt

3 (b) If veteran, name war: World 1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine L. Schmidt

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 11-1892

8. AGE: Years 53 | Months 5 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Aug L. C. Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Lagrenade
15. Birthplace Germany

16 (a) Informant Mrs. Josephine L. Schmidt
(b) Address 104 S Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Leerich Funeral Home
(b) Address 2007 Orleans St

JAN 9 - 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 19 46, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Gelbrich M.D.
Medical Examiner.
Date signed 1/6/46

VS-151

36199

485906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 A

Registered No. 36199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)
(d) Street No. Jordan Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Marjorie Gellenbeck.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White.	married

6 (b) Name of husband or wife Harry.
6 (c) If alive, give age 39. years

7. Birth date of deceased (mo., day, yr.) 1-16-08

8. AGE: Years	Months	Days	If less than one day
37.	11	22	hr. min.

9. Birthplace New York.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name John Orth
13. Birthplace Ireland.

MOTHER
14. Maiden Name Jessie Brennan
15. Birthplace Ireland

16 (a) Informant Reenda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal. (b) Date thereof Jan 11 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hanover
Location Hanover Pa.

18 (a) Funeral director W. G. Feiser
(b) Address Hanover Pa.

JAN 9 - 1946
(Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8. 1946. at 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1945. to Jan. 8 1946. and that I last saw her alive on Jan. 8 1946.

Immediate cause of death: Anemia + Cachexia — Duration 2 mo

Due to: Hepatic Insufficiency — Duration ?

Due to: Cirrhosis of Liver + Acute Liver Necrosis — Duration ?

Other Conditions: Cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurel Dickson M.D.
Address Johns Hopkins Hospital Date signed 1/8/46

VS 150

36200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G36200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 Reservoir street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Reservoir st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Elizabeth Gorman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank B. Gorman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 82 years			hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name -------- Marceron
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Thompson
15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Frank P. Stack
(b) Address 616 Reservoir street

17 (a) Burial (b) Date thereof 1/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore, Maryland

18 (a) Funeral director H. W. Meadows
(b) Address 805 North Calvert st.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1946 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Jan 7 1946 and that I last saw her alive on Jan 7 1946

Immediate cause of death Heart Failure — Duration 2 days.

Due to Cardio Vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmunds Jr. M. D.
Address Med-Lex's Bldg Date signed Jan 8 1946

G36201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1/8/46

G36201 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2 746 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mexico (b) County
(c) City or town Tampico
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Morena St.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Mexico

3 (a) FULL NAME Perez, Robert Adolfo (Robert Adolfo Perez)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Maria Perez
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1907

8. AGE: 38 Years 39 Months 3 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace Sinnona, Mexico
(Town, county, and state)
10. Usual Occupation 2nd mate
11. Industry or business Seafarer

FATHER
12. Name Jose Perez
13. Birthplace Mexico

MOTHER
14. Maiden Name Luz ?
15. Birthplace Mexico

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 1/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (b) Huntington Mill, Penna.

JAN 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1946 12:10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1945, to Jan. 6 1946, and that I last saw him alive on Jan. 6 1946.

Immediate cause of death: Uremia — Duration: Unknown

Due to Chronic glomerulonephritis with renal failure — Duration: Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 1/8/46
US Marine Hospital, Balto, Md.

36202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 36202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1347 W. North Ave,.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. BRISCOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace Howard Co, Maryland (Town, county, and state)

10. Usual Occupation House Maid

11. Industry or business

FATHER
12. Name George Nettles
13. Birthplace Howard Co,. Maryland

MOTHER
14. Maiden Name Ellen Johnson
15. Birthplace Montgomery Co,. Maryland

16 (a) Informant Cora Nettles
(b) Address 1347 W. North Ave, Balto,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 46 (month) (day) (year)
(c) Cemetery or crematory Brooks Cemetery
Location Howard County Md

18 (a) Funeral director Mowbray & Davis
(b) Address Rockville Md

JAN 9 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 7th 1946 at 1120 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan 7 1946 and that I last saw h[illegible] alive on Jan 7 1946

Immediate cause of death: Arteriosclerotic Cardio Vascular Disease — Duration: 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Rockville Md Date signed 1/9/46

VS 150

G36203 BALTIMORE CITY HEALTH DEPARTMENT G36203

CERTIFICATE OF DEATH 542 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5727 First Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David E. Horseman

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 217-09-2521

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dora E.

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1900

8. AGE: Years 46 | Months -- | Days 8 7 | If less than one day hr. min.

9. Birthplace Taylors Island Md. (Town, county, and state)

10. Usual Occupation Maintainee

11. Industry or business Furniture

FATHER
12. Name Martin E. Horseman
13. Birthplace Taylors Island Md.

MOTHER
14. Maiden Name Mary Ruarak
15. Birthplace Taylors Island Md.

16 (a) Informant Mrs. Nina Engles
(b) Address 5727 First Ave. Halethorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) Filed JAN 9 - 1946 (b) Signature of registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1946 at 2:18 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1945 to 1/8 1946 and that I last saw him alive on 1/8 1946.

Immediate cause of death Cardio-respiratory failure - cerebral edema. — Duration

Due to Infiltrating glioma parietal lobe left hemisphere brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-3-46

Major findings of operation: Infiltrating Glioma Left Parietal Hemisphere brain

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. McFadden M. D.
Address St Agnes Hosp. Date signed 1-8-46

VS 150

Instructions: Please write the causes of death clearly and legibly.

Dr. Bernard Kelly
100 N. Linwood Ave.
G36201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

REGISTERED No. G36201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2332 Aiken Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2332 Aiken Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Duffy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1922

8. AGE: Years	Months	Days	If less than one day
23	10	25	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER
12. Name William J. Duffy
13. Birthplace Md.

MOTHER
14. Maiden Name Winifred J. Flaherty
15. Birthplace Md.

16 (a) Informant Mr. William J. Duffy
(b) Address 2332 Aiken Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form JAN 9 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1941 to Jan 7 1946, and that I last saw h[illegible] alive on Jan 7 1946

Immediate cause of death: Coronary Thrombosis
Due to: Coronary thr
Due to:
Other Conditions: Myocarditis, Hypertension
(Include pregnancy within three months of death)
Date of operation 1/4
Major findings of operation: none
of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B.V. Kelly M. D.
Address 100 N Linwood Ave Date signed Jan 8/46

G36205 City

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700

G36205

Reg. Dist. No. 27

1. PLACE OF DEATH: ~~Washington Blvd near Jessup, Md.~~

City Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

If in above place of death?
Name of institution, or street address where death occurred:
St. Agnes, Hospital, Baltimore, Md.
If in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New York County Queens County

City or town Forest Hill, N. Y.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 150 Burns St.
(If rural, give LOCATION)

2.(a) If veteran, name war

FULL NAME: ALBERT D. SMITH

3.(b) Social Security Number

4. Color or race	5.(a) Single, married, widowed, or divorced
White	Single

If married, widowed, or divorced, name of husband or wife

5.(c) If alive, give age years

6. Date of death (mo., day, yr.) 11 November 1925

7. Years	Months	Days	If less than one day
	1	20	hrs. min.

8. Birthplace (Town, county, and state)

Usual occupation

Kind of industry or business: Soldier - U. S. Army

Name of father: Unknown

Birthplace of father: Unknown

Maiden name of mother: Unknown

Birthplace of mother: Unknown

Informant: Unknown

Address: Unknown

Burial, cremation, or removal. Which?) Date thereof 11/3/46
(month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Address Arlington, Va.

Undertaker Howard W. Blight Jr.

Address 4914 Belair Road, Balto., Md.

Date received 9 - 1946 by registrar 10 Januar 46

Registrar's signature: Frank J. Tollison, Capt., MC

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Dec. 1945 at M

21. I CERTIFY that death occurred on the date above stated: (over)

and that I last saw h... alive on ... 19..., to ... 19...

Immediate cause of death: Inter-cranial hemorrhage due to concussion.

DURATION

Due to: Injuries received in automobile accident.

Due to: Concussion - 31 December 1945

Other conditions: Fracture of jaw and multiple contusion

(Include pregnancy within 3 months of death)

Major findings of operations: None performed

Date of op.

Autopsy results: Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Hour of Inj.

Accident, suicide, or homicide: Accident Date of 31 Dec. 45

Where did injury occur? Washington Blvd near Jessup, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Manard M. Tuler, Maj. MC
M. D. or other

Address: ASN 0-430982 Date signed 3 Jan. 1946

G36205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 Battery Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Battery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Jr. Schubert

3 (b) If veteran, name war: War #1

3 (c) Social Security Account No. 214-03-0194

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Janie Leonhardt

(c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
55 54			hr. min.

9. Birthplace Maryland
(Town, county and state)

10. Usual Occupation Merchant

11. Industry or business Cross St. Market

FATHER
12. Name Jerome C. Schubert
13. Birthplace Md.

MOTHER
14. Maiden Name Mary L. Bond
15. Birthplace Md.

16 (a) Informant Mrs J. H. Schubert
(b) Address Route #2 Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Avenue

18 (a) Funeral director John F Denny Inc
(b) Address 5 E Eight St.

JAN 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7th 1946 at 5 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1-9 1945 to Jan. 7 1946, and that I last saw him alive on Jan 6 1946

Immediate cause of death: Acute Cardiac Failure — Duration

Due to: Chronic myocarditis, Chronic hypertension.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. S. H. Barranco M. D.

Address 436 E Fort Ave Date signed 1/8/46

VS 150

G36207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36207 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mon.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ira Joseph Sheckells

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22 45

8. AGE: Years	Months	Days	If less than one day
	3	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elmer Sheckells
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ethel Hamilton
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-46 (month) (day) (year)
(c) Cemetery or crematory St Mary's Otterbein
Location Baltimore Md

18 (a) Funeral director Frank H Leist
(b) Address 814 N. 36th St

19 (a) (b)
(Signature of local registrar)

JAN 9 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1946, at 4:11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1946 to Jan 8, 1946, and that I last saw him alive on Jan 8 1946.

Immediate cause of death: Broncho pneumonia, bilateral. — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M. D.
Address Union Memorial H. Date signed 1/8/46

G36208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

~~G36208~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3242 Keswick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 3242 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha J Danner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife David Danner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 - 1895

8. AGE: Years 50 | Months 4 | Days 6 5 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic wife

11. Industry or business

FATHER
12. Name Alexander Allen
13. Birthplace unknown

MOTHER
14. Maiden Name Teressa Augenbright
15. Birthplace unknown

16 (a) Informant David Danner
(b) Address 3242 Keswick Rd

17 (a) Burial (b) Date thereof 1 - 10 - 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Baltimore

18 (a) Funeral director Frank H Leahy
(b) Address 814 W 36 St

19 (a) JAN 9 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1941 to Jan 7 1946, and that I last saw h— alive on Jan 7 1946

Immediate cause of death Lymphosarcoma — Duration
Metastatic
Due to Secondary Anemia
Due to Syphilis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. G. Reader M. D.
Address 2314 - W. North Ave Date signed 1/8/46

G36209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G36209 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1241 Wash. Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marie Newman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Marion B. Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Armstrong
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Pa.

16 (a) Informant Jane Thompson (Daughter)
(b) Address 1241 Wash. Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.

18 (a) Funeral director Harry H. Rukert
(b) Address 4101 E. Monument Ave.

19 (a) (Date rec'd by reg.) (b) Registrar Williams M.D.

VS JAN 9 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1946, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1945 to 1/6 1946 and that I last saw her alive on 1/6 1946.

Immediate cause of death: Cardio Resp failure — Duration

Due to: Terminal Pneumonia

Due to: Far advanced Portal Cirrhosis

Other Conditions: Localized Peritonitis & Pericholecystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Chas. L. Carroll Jr.
Address St. Agnes Hosp. Date signed 1/7/46

Type or print plainly in ink. Physicians: please write clearly. Be sure the causes of death clearly and legibly.

G36210 G36210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 A 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6100 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELDRED ROBERTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Corinthia (Caldwell)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1896

8. AGE: Years	Months	Days	If less than one day
49	4	1	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Edward J Roberts
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Rankin
15. Birthplace Scotland

16 (a) Informant Mrs Corinthia Roberts
(b) Address 6100 York Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 10 1946 (month) (day) (year)
(c) Cemetery or crematory Philos
Location Western Port Md

18 (a) Funeral director Harry F Witzke
(b) Address 4101 Edmondson Ave

19 (a) Jan 9 1946 (Date rec'd by registrar) (b) Huntington Williamsport Md (Address)

JAN
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7/46 19 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Cardio Respiratory Failure

Due to Suicide (Barbital Poisoning)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/7/46 at approximately 5 P.M.
(b) Where did injury occur? 6100 York Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Self Inflicted Barbital

23. Signature John R Davis M.D. (Medical Examiner)
Date signed 1/7/46

G36211 ✓ G36211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 2698 Dulaney St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Bessie B Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f | 5. Color or race w. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George F. Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1888

8. AGE: Years 57 58 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Henry Wagner
13. Birthplace Md

MOTHER
14. Maiden Name Emilie Hartman
15. Birthplace Md

16 (a) Informant husband George F. Harris
(b) Address 2698 Dulaney St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10 46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood St

18 (a) Funeral director Harry H. Wilke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) JAN 9 1946 (b) Huntington Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 19 46 at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 19 46 to 1/7 19 46.
and that I last saw her alive on 1/2 19

Immediate cause of death	Duration
Cardiac failure	
Due to Complete Heart Block	
Due to Acute Coronary Thrombosis	
Other Conditions Hypertension C-Vitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. L. Cox Jr.
Address St Agnes Hosp. Date signed 1/7/46

G36212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Eutaw St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 293 S. Eutaw St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Schneider

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Christian Schneider
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 20, 1872

8. AGE: Years 73 | Months 5 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Unknown Beck
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Pfeiffer
15. Birthplace Maryland

16 (a) Informant Charles Schneider
(b) Address Cpl. 20 Route 15 Kingston Road, Middle River

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

19 (a) JAN 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1946, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1946, to 1/8 1946, and that I last saw her alive on 1/8 1946.

Immediate cause of death: Cerebral Vascular Accident — Duration

Due to Arteriosclerosis

Due to Cerebral Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature Bobby E. Owens M. D.
Address Randallstown Pack Rd. Date signed 1/8/46

636213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

831 ✓ Registered No. 636213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 557 Presstman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 557 Presstman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH BRYAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Thomas H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9, 1876

8. AGE: Years 70 | Months 9 | Days 25 | If less than one day hr. min.
69

9. Birthplace Louisianna
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mamie Stevens
(b) Address 557 Presstman St

17 (a) Burial (b) Date thereof Jan. 9, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 9 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/46 19 , at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner.
Date signed 1/5/46

G36214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G36214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 629 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1931

8. AGE: Years	Months	Days	If less than one day
14 ~~15~~	5	27	hr. min.

9. Birthplace Baltimore, Md
(City or county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Joseph Parker
13. Birthplace Kinston, N.C.

MOTHER
14. Maiden Name Mary Cotter
15. Birthplace Phila. Pa.

16 (a) Informant Mary C. Skinner
(b) Address 629 N. Schroeder St

17 (a) Burial (b) Date thereof Jan 12, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Chas. H. Hyllan
(b) Address 1631 Druid Hill Ave

19 (a) JAN 9 - 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1946 at 1 P. M. 35

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-8-46 at 1 A. M.
(b) Where did injury occur? Vicinity of 1310 Edmondson Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shooting

23. Signature Robert A. Gerstein M.D.
Medical Examiner.
Date signed Jan 8 1946

VS 151

X

G36215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA HAIMEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Harry Hammel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1861

8. AGE: Years	Months	Days	If less than one day
about 84			hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Conrad Miller
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Russel D. Miller
(b) Address 1847 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 9 - 1946 (Date rec'd by Registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1944, to Jan 6 1946, and that I last saw her alive on Jan. 4 1946

Immediate cause of death	Duration
Chronic myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Fetterman M. D.
Address 7324 Reisterstown Rd Date signed 1/3/46

VS 150

X

G36216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 42

Registered No. G36216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital V 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Aphelby Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William W. Livingston

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	215-01-5421

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lola May Livingston
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 7, 1896

8. AGE: Years	Months	Days	If less than one day
49	10	1	hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Dry Cleaner
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Zell Harrison
(b) Address 1600 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Balttmore National
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 9 - 1946 Received by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1946 at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Kidney Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schmidt M.D.
Medical Examiner.
Date signed 1/8/46

VS 151

G36217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36217
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 Bloom St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 520 Bloom St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Whittington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife William Whittington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1856

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Felix Hope
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Calvert Co. Md.

16 (a) Informant Chas Randall
(b) Address 579 Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Williams, M.D. (Registrar)

JAN 9 — 1946
VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5, 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Jan 5 1946 and that I last saw her alive on Jan 5 1946

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr.
Due to Hypertension	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E William Frey M. D.
Address 1928 Penna Ave Date signed 1/8/46

6218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1-312

Registered No. G36618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 E 28 St
(c) Hospital or institution: 9-F
(d) Length of stay in hospital or inst. (yrs., mos., or days) Nov 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 E. 28th Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES F. NAGLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widower

6 (b) Name of husband or wife Georgiana
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1859

8. AGE: Years	Months	Days	If less than one day
86	6	5	13 22 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Fred Wm Nagle
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Julia Amey
15. Birthplace Baltimore Md

16 (a) Informant Mrs Sarah (Daughter)
(b) Address 1826 E 28

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 JAN 9 - 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1946, at 2 12 am M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1945 to Jan 8 1946, and that I last saw him alive on Jan 7 1946

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	2 D.
Due to (b) Arteriosclerosis	3 Y.
Due to (c) Chronic Interstitial Nephritis	15 Y.
Other Conditions	15 Y.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F A Stevens
Address 2878 Harford Date signed 1-8-46 M. D.

VS 150

G36219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3209 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine Alexander Weglein

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	213-03-4473

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sophia Johanna Weglein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1877

8. AGE: Years	Months	Days	If less than one day
68	6	25	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Box Maker
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Conrad Weglein
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Katherine Reese
15. Birthplace Baltimore, Maryland

16 (a) Infosmant Mr. Edward Weglein -son
(b) Address 3209 Fleet street

17 (a) Burial (b) Date thereof 1-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, Inc.
(b) Address NORTH AVE. & BROADWAY

JAN 9 - 1946 Huntington Williams, M.R.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8- 1946 at 11.30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy on [illegible] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stalsworth M.D.
Medical Examiner.
Date signed Jan. 8, 1946.

VS 151

36220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1812

Registered No. G36220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 431 N. Patterson Park Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 N. Patterson Park Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN ERNEST HEISNER, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Mary E. Heisner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1867

8. AGE: Years	Months	Days	If less than one day
78	8	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business City of Balto. - Ret.

FATHER
12. Name John E. Heisner
13. Birthplace Germany

MOTHER
14. Maiden Name Margretha ?
15. Birthplace ?

16 (a) Informant John Ernest Heisner-3rd.
(b) Address 4323 Sheldon Avenue

17 (a) Burial (b) Date thereof 1-10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 9 - 1946 (b) Huntington Killiam, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1946 to ——— 19 . and that I last saw him alive on Jan 7 1946.

Immediate cause of death Coronary Thrombosis — Duration 6 hrs.
Due to
Due to
Other Conditions Cardio-vascular renal disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry A. Kane M. D.
Address 2607 E. Preston St. Date signed 1-9-46

VS 150

G36221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josefa Jelinek

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1865

8. AGE: Years	Months	Days	If less than one day
80	9	20	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant: Mrs. Constantin Scheuring
(b) Address 2430 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) JAN 9 - 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 05

20. DATE OF DEATH Jan. 7th. 1946 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1945 to Jan 6 1946.
and that I last saw h[er] alive on Jan 6 1946

Immediate cause of death: General Arteriosclerosis — Duration 10 yrs
Due to: Chronic Myocarditis — Duration 10 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon M.D.
Address 129 S. Broadway Date signed 1/8/46

G36222 G36222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3817 Mt Pleasant Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Basto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 Mt Pleasant Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary W. Gransee

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married

6 (b) Name of husband or wife William J
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept 22 1886

8. AGE: Years	Months	Days	If less than one day
59	3	14	hr. min.

9. Birthplace Basto (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Richard Hoffeld
13. Birthplace Germany

MOTHER 14. Maiden Name Charolette ?
15. Birthplace Germany

16 (a) Informant William J Gransee
(b) Address 3817 Mt Pleasant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory H. Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dept of Serv
(b) Address Lombard & Hanover Sts.

19 Filed JAN 9 - 1946 (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 at 10:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11-45 19 to 1-6-46 19, and that I last saw her alive on 1-4-46 19

Immediate cause of death	Duration
Metastatic Carcinoma of Spine	
Due to Carcinoma of Breast (Left)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.
Address 23 W. S. Conkling (Date signed 1-7-46

G36223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G36223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 East 21st Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 East 21st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C. COLGAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ann J. Colgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1872

8. AGE: Years 73 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace: Harford Co., Md. (Town, county, and state)
10. Usual Occupation: Motorman-Balto. Transit (Ret.)
11. Industry or business

FATHER
12. Name: Ed. J. Colgan
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Irene Bagley
15. Birthplace: Harford Co., Md.

16 (a) Informant: Mrs. John C. Colgan
(b) Address: 516 East 21st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cemetery
Location: Long Green

18 (a) Funeral director: [illegible]
(b) Address: [illegible]

19 JAN 9 - 1946 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7/46 19... at 8:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 7 1946 and that I last saw him alive on Jan 7 19 46

Immediate cause of death: Lobar pneumonia — Duration: 6 days
Due to:
Due to:
Other Conditions: Arteriosclerosis — —

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Edward Novak M. D.
Address 101 W. Read ST Date signed 1-9-46

VS 150

G36224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V92B

Registered No. G36224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 N. Bruce St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1889

8. AGE: Years	Months	Days	If less than one day
56 57	8	5	hr. min.

9. Birthplace St. Marys Co Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name Lottie Watts
15. Birthplace Md

16 (a) Informant Joseph Barnes
(b) Address 519 Kenly Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 W. Lexington St.

19 JAN 9 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946, at 12 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1945 to Jan 6 1946, and that I last saw h.i.m. alive on Dec 29 1945.

Immediate cause of death	Duration
Cardiac insufficiency	
Due to Mitral insufficiency	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Shepperd M. D.
Address 1431 W. Franklin Date signed 1-8-46

G36225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

G36225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 N. Glover Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Glover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. KASPAR

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Joseph J. (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1865

8. AGE: Years	Months	Days	If less than one day
80 yrs.	5	22	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Francis Holub
13. Birthplace Czech.

MOTHER
14. Maiden Name Barbara Beran
15. Birthplace Czech.

16 (a) Informant Anna Velenovsky - daughter
(b) Address 823 N. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Filed by ~~JAN 9 - 1946~~ (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1946 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Jan 6 1946 and that I last saw h[illegible] alive on Jan 6 1945

Immediate cause of death Coronary Occlusion — Duration 1/4/46

Due to

Due to Chr. Myocarditis — 1/1/1945

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Kasper M.D.
Address 801 E. Kenwood Ave. Date signed 1/8/46

G36226 — BALTIMORE CITY HEALTH DEPARTMENT — G36226 Registered No.

CERTIFICATE OF DEATH

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 733 Harford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Harford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** David Forte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	29	hr. min.

9. Birthplace N. Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Forte
13. Birthplace N. C.

MOTHER
14. Maiden Name Maria Hawkins
15. Birthplace N. C.

16 (a) Informant James Forte
(b) Address 733 Harford ave

17 (a) Removal (b) Date thereof Jan 12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Middleton N. Carolina

18 (a) Funeral director Mrs. Robert A. Elliott Sr.
(b) Address 1129 N. Caroline St.

19 (a) (Date received by registrar) JAN 9 1946 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1946, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Jan 1946, and that I last saw him alive on Jan 6 1946.

Immediate cause of death	Duration
acute Respiratory Failure	
Due to Pneumonia	3 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell M. D.
Address 121 Augusta Date signed 1-9-46

X

G36227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G36227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 W. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert James Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Pernice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1923

8. AGE: Years 22 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Winsboro, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Kennedy
13. Birthplace Winsboro, S.C.

MOTHER
14. Maiden Name Viola Cook
15. Birthplace Winsboro, S.C.

16 (a) Informant John Kennedy
(b) Address

17 (a) Shipped (Burial, cremation or removal) (b) Date thereof Jan. 11, 46 (month) (day) (year)
(c) Cemetery or crematory
Location Winnsboro, S.C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) Date received [illegible] (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1946, at 11:15 A.M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculous meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Jan. 8 1946

VS 151

G36228

TN. 97533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36228 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-mo 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Henry Durham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17th 1923

8. AGE: Years	Months	Days	If less than one day
22	10	17	hr. min.

9. Birthplace N. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Durham
13. Birthplace N. C

MOTHER
14. Maiden Name Bessie Bullock
15. Birthplace N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Shipped (b) Date thereof Jan. 10, '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Henderson, N.C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 1946 Schroeder St

19 (a) JAN 9 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th. 1946 19 at 2.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27-45 19 to 1-4-46 19, and that I last saw h im alive on Jan. 4th 19 46

Immediate cause of death: Tuberculous Peritonitis / Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert K. Boland Jr. M.D.
Address Balt. City Hosp. Date signed 1/8/46

X

G36229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3413 E. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 E Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. Beck

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Columbus Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1307

8. AGE: Years 89 | Months 6 | Days 3 | If less than one day hr. min. 24

9. Birthplace Rockhall Md
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Jackson Cluss
13. Birthplace Rockhall Md

MOTHER
14. Maiden Name Eliza Grant
15. Birthplace Rockhall Md

16 (a) Informant Columbus Beck
(b) Address 3413 E Lombard St

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oakley Church Cem
Location Rockhall Md

18 (a) Funeral director Wendell Hopper
(b) Address 312 S Highland Ave

19 (a) (b)
Registrar

JAN 9 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5-46 19 , at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17-45 19 to 1-5-46 19 and that I last saw h[illegible] alive on 1-5-46 19

Immediate cause of death — Duration
Enterocolitis Ileus
Vomiting Diarrhea
Due to Enterocolitis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino, MD M. D.
Address 227 S Conkling Date signed 1-9-46

G36230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1181

G36230
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or Institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 2021 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Posey Altizer

3 (b) If veteran, name war

3 (c) Social Security Account No. 236-10-8885

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora D. Altizer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1907

8. AGE: Years	Months	Days	If less than one day
38	2	29	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Steam Sitter
11. Industry or business Holland Laundry

FATHER
12. Name James Merritt
13. Birthplace Virginia

MOTHER
14. Maiden Name Callie Cummings
15. Birthplace West Va.

16 (a) Informant Mrs. Cora D. Altizer
(b) Address 2021 Eutaw Place

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-9-46 (month) (day) (year)
(c) Cemetery or crematory Local
Location Rathord, Virginia

18 (a) Funeral director Wm. J. Dickerson & Sons
(b) Address 414 Pelham Ave., Balto, Md.

19 (a) Date received JAN 9 1946 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 1946 at 8:55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Second and third degree burns of face, chest & left upper extremity

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 6 Dec 1946 at 9:30 P M
(b) Where did injury occur? 2021 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Bed clothing caught after

23. Signature William G. Reinhardt M.D.
Medical Examiner.
Date signed 9 January 46

Dr. Goiley G36231
5100 Bk. Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G36231
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2514 Strathmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2514 Strathmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Koegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Peter Koegel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1864

8. AGE: Years 81 Months -- Days 17 If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Eva Juengst
(b) Address 2514 Strathmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road -14-

JAN 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/46 to 1/9 1946.
and that I last saw h alive on 1/8 1946

Immediate cause of death Cholecystitis
Myocarditis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hy Oct Talley M. D.
Address 5702 Harford Ave. Signed 1/9/46

VS 150

Dr. Anderson
Shannon Drive

G362232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G362232

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4023 Parkside Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4023 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel T. Peters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John Peters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1877

8. AGE: Years 68 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name ? Tilghman
13. Birthplace Ohio

MOTHER
14. Maiden Name ? Wright
15. Birthplace New York

16 (a) Informant: Mrs. Diller
(b) Address 4023 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore

18 (a) Funeral director: Leonard J. Runk
(b) Address 5305 Harford Road

19 (a) (Date) 1946 Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8th, 1946, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Jan 8 1946 and that I last saw her alive on Jan 7 1946. Immediate cause of death: Bronchio Pneumonia — Duration

Due to: Influenza Virus

Due to: Chronic Myocarditis Cardiac Asthma

Other Conditions: Hypertension Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Walter A Anderson M. D.
Address 3001 Hampden Ave Date signed Jan 8-46

VS 150.

G36233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G36233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - (If outside city or town limits, write "Out" and give town)
(d) Street No. 915 N Carrollton Ave - (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Premature Hector

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife December 28, 1945

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Gornia Hector

15. Birthplace Unknown

16 (a) Informant Police Report.

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY JAN 9 1946 Commissioner of Health

18 (a) Funeral director

(b) Address

19 JAN 9 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Dec 1945, at 3 15 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hernia incarcerated, Umbilical

Due to Prematurity.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm L Nalpath M.D.
Medical Examiner.

Date signed 29 Dec 45

VS 151

36234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36234 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Chambers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years | Months 7 | Days | If less than one day ____hr. ____min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Russell Chambers
13. Birthplace Unknown

MOTHER
14. Maiden Name Lucille"
15. Birthplace "

16 (a) Informant Police Report
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JAN 9 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 9 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1945 at 4 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Confluent lobular pneumonia, bilateral
Due to Dehydration, marked.

Other Conditions Malnutrition
Rickets
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Gutierrez M.D. Medical Examiner.
Date signed 12-31-45

VS 151

G36235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

G36235 Registered No.

HB #98126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years 78? Months Days If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mars Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Peggy ?
15. Birthplace Va.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-46 (Month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Watson
(b) Address 1000 Brentleyard

19 (a) 1-9-1946 (Date) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1946 at 3:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28, 1945 to Jan. 4, 1946 and that I last saw h[illegible] alive on Jan. 4, 1946

Immediate cause of death: Cerebrovascular accident — Duration

Due to: arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B. C. H. Date signed 1/7/46

VS 150

Use the causes of death clearly and legibly. Write all entries in ink. Do not use abbreviations. Be sure every important item is supplied.

G36236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 D

G36236 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2360 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Lauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna E. Lauer
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) August 29, 1891

8. AGE: Years	Months	Days	If less than one day
54	4	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Produce Dealer
11. Industry or business

FATHER
12. Name Jacob Lauer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lida Coker
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Anna E. Lauer
(b) Address 2360 Washington Blvd.

17 (a) Burial (b) Date thereof Jan. 12, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cemetery
Location Meadowridge, Md.

18 (a) Funeral director Willis Lawrence
(b) Address 1005 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

Jan 9 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1946, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1945 to 1/9 1946, and that I last saw him alive on 1/8 1946

Immediate cause of death	Duration
Cachexia	
Due to Carcinoma Lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strober M. D.
Address Jno. Hop. Date signed 1/9/46

X

G36237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36237

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Dorsey, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Noakes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1887

8. AGE: Years	Months	Days	If less than one day
59	6	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

MOTHER / FATHER

12. Name Sam Noakes
13. Birthplace Md.
14. Maiden name Priscilla Briggs
15. Birthplace Md.

16 (a) Informant Delma Noakes
(b) Address Dorsey, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 1946 (month) (day) (year)
(c) Cemetery or crematory St Mathews
Location Harmony Md.

18 (a) Funeral director The Stac-White Co Inc
(b) Address Laurel Md

JAN 10 1946 (Date received) (By) Huntington Williams Funeral Home

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9-1946 at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1946 to 1-6-1946 and that I last saw h alive on 1-6-1946.

Immediate cause of death: Cerebro vascular accident

Due to: Hypertensive Cardio Vascular Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-2-46

Major findings of operation: Inguinal hernia

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. K. Kenemain M. D.
Address Franklin Square Hospital Date signed 1-9-46

636238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. 636238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Arthur Heiges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband/wife Jessie Heiges

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1894

8. AGE: Years	Months	Days	If less than one day
51	2	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER 12. Name John Heiges
13. Birthplace Balto.

MOTHER 14. Maiden Name Mary Shaffer
15. Birthplace Balto.

16 (a) Informant Mrs Jessie Heiges
(b) Address 1130 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F Henny Sue
(b) Address 7 N Light St.

19 (a) JAN 10 1946 Washington Wilmington M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1946 6:34 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1945 to Jan 9 1946 and that I last saw him alive on Jan 9 1946

Immediate cause of death	Duration
Nephro-sclerosis	
Due to (a) with malignant hypertension	
Other Conditions Partial Coronary occlusion	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ateroma of left kidney - infarct of myocardium

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Wheeler M.D.

Address South Balto-Gen. Hosp. Date signed 1/9/46

VS 180

G36239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G36239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 Hilton ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Hilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James B Wisner

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Goldie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1884

8. AGE: Years	Months	Days	If less than one day
61	1	21	hr. min.

9. Birthplace West Virginia Md
(Town, county, and state)

10. Usual Occupation Electrician
11. Industry or business Pub Utility

FATHER
12. Name Jacob Wisner
13. Birthplace Pa

MOTHER
14. Maiden Name Katherine Murdock
15. Birthplace Baltimore Md

16 (a) Informant Robert Wisner
(b) Address 3849 Keary Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director Belhomme Funeral Dir
(b) Address 1217 N Fond St

19 (a) JAN 10 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946 at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1946 to Jan 7 1946 and that I last saw alive on Jan 7 1946

Immediate cause of death: Myocardial failure — Duration: 1 day
Due to: Cirrhosis of liver
Due to: Chronic alcoholism
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L Sunglass MD
Address 50 E Lanvale Date signed 1-9-46

VS 150

636240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Provident Hospital Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Ann Patten

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1845

8. AGE: Years	Months	Days	If less than one day
100	1	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Patten
13. Birthplace Mass

MOTHER
14. Maiden Name Harriet Edwards
15. Birthplace Md

16 (a) Informant Mrs. Coates
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director William H. Foster
(b) Address 1517 N. Eutaw St. Baltimore, Md.

19 (a) JAN 10 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1946, at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Dec 8 1946, and that I last saw h[illegible] alive on Dec 8 1946.

Immediate cause of death	Duration
Myocardial Insufficiency	10 days
Due to Arterio sclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J. Davis M. D.
Address 800 N 33rd Date signed 1-9-46

VS 150

G36241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36241 Registered No. 310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 842 W 36th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 W 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor E. Duering

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1855

8. AGE: Years	Months	Days	If less than one day
90	9	25	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name George S. Duering

13. Birthplace Maryland.

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown.

16 (a) Informant Mrs. Mary E. Ward

(b) Address 842 W 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Cathedral

Location Frederick Road

18 (a) Funeral director Ehrenwald & Donovan

(b) Address 3615-17 Chestnut Ave.

19 JAN 10 1946 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1927 to Jan 8 1946 and that I last saw her alive on Jan 7 1946

Immediate cause of death Cardiac Decompensation — Duration 5 days.

Due to Aortic-vascular-renal disease — 15 yrs.

Due to

Other Conditions None.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas Duering

Address 846 W 36th St. Date signed 1/9/46

VS 150

X

G36242 ✓ G36242

G36242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l. Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE M. BERRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Thomas Berry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1/4/1860

8. AGE: Years	Months	Days	If less than one day
86	0	4	hr. min.

9. Birthplace: Balto., Md.
(Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Daniel Mathaney
13. Birthplace: Va.

MOTHER
14. Maiden Name: Louise P. Morris
15. Birthplace: Md.

16 (a) Informant: Miss Grace M. Berry
(b) Address: 2005 Guilford Ave.

17 (a) Burial (b) Date thereof 1/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 10 1946 Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: Jan. 8, 1946 at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1946, to 1/8 1946, and that I last saw h.E.R alive on 1/8 1946

Immediate cause of death	Duration
ATELECTASIS	½ Day
Due to	
Due to	
Other Conditions ATROPHIC CIRRHOSIS OF LIVER (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: SAME AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature: Charles W. Stewart Jr. M.D.
Address: M. G. H. Date signed 1/10/46

114E

G36243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G36243 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write plainly. Do not abbreviate. Use only accepted medical terminology. Improper or illegible entries will be returned for correction.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Southview Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE PHILLIPS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Howard S. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 29, 1875

8. AGE: Years 70 | Months 5 | Days 9 10 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

FATHER
12. Name: ? Schoff
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Elizabeth ?
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Howard S. Phillips
(b) Address: 3706 Ellerslie Ave.

17 (a) Burial (b) Date thereof 1/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Willis M.D.

JAN 10 1946

MEDICAL CERTIFICATION A.

20. DATE OF DEATH 1/8/46 19 , at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 DEC 1945 to 8 JAN 1946 and that I last saw her alive on 7 JAN 1946

Immediate cause of death	Duration
Acute Cardiac Dilatation	13 days
Due to Chronic Myocarditis	
Due to	
Other Conditions Diabetes Mellitus	5 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed 8 Jan 46

93D

2-23-61

G36244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36244 Registered No. 1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JAMES DUN BRACCO

3 (b) If veteran, name war Nada

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary A. Dumbracco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1861

8. AGE: Years	Months	Days	If less than one day
84	10	16	hr. min.

9. Birthplace Queen Anne's Co., Md.
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name James Dunbracco
13. Birthplace Queen Anne's Co., Md.

MOTHER
14. Maiden Name Annie E. Vandeford
15. Birthplace Easton, Md.

16 (a) Informant Mrs. Sue Walton Broome
(b) Address 1108 Ashburton St.

17 (a) Burial (b) Date thereof 1/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chestertown, Md.
Location

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1946, at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5. 1946 to Jan 9 1946, and that I last saw him alive on Jan. 9 1946.

Immediate cause of death Uraemia

Duration

Due to Chronic glomerular nephritis and Benign Prostatic hypertrophy

Other Conditions Senility, Injury and Burns
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address University Hosp. Date signed 1/9/46 M. D.

1313

G36445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36445 No.

Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Windsor Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE RAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Grafton Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1854

8. AGE: Years	Months	Days	If less than one day
91	1	26	hr. min.

9. Birthplace Howard Co.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Davis
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Howard Co., Md.

16 (a) Informant Mrs. Mary Forrester
(b) Address 2819 Windsor Ave.

17 (a) Burial (b) Date thereof 1/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Ellicott City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Ellicott City, Md.

19 (a) JAN 10 1946 (b)
(Date rec'd by registrar) Registrar

VS 130

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Jan. 8, 1946 at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1946 to Jan 8 1946 and that I last saw her alive on Jan 7 1946.

Immediate cause of death Chronic Myocardial Degeneration — Duration 6 yrs
Due to
Due to
Other Conditions Hypostatic Pneumonia 2 days
Senility
(Include pregnancy within 3 months of death)
Date of operation no operation
Major findings of operation:
of autopsy: no autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joshua N. Arnscott M. D.
Address 2419 Windsor Ave Baltimore-7 Jan 9 1946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36246 ✓ G36246 83a Registered No.

Please write the causes of death clearly and legibly. Physicians: please write plainly. Incorrect age is frequently important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 S.Curley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 S.Curley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Weglein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Weglein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug.9-1879

8. AGE: Years 66 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Street Cleaner

11. Industry or business Balto. City

FATHER
12. Name Conrad Weglein
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Reese
15. Birthplace Balto. Md.

16 (a) Informant Julia Weglein
(b) Address 642 S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.12/46 (month) (day) (year)
(c) Cemetery or crematory Morland Memorial Pk.Cem.
Location Taylor Ave.

18 (a) Funeral director John A.Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

VS 1950 JAN 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1946, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1946 to 1-8-1946, and that I last saw h. alive on 1-8-1946

Immediate cause of death	Duration
Cerebral Hemorrhage	7 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Davidow M. D.
Address 3218 Edstern Ave Date signed 1-9-46

X

G36247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36247 Registered No.

10

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G36248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G36248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 BATTERY AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 BATTERY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND LEO CAREY

3 (b) If veteran, name war: WORLD WAR 1

3 (c) Social Security Account No. 705-10-2884

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: EMMA MAY

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) SEPT. 22 1893

8. AGE: Years 53 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business BETHLEHAM SHIP YARD

FATHER
12. Name JAMES H. CAREY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ELLA HOLMES
15. Birthplace MARYLAND

16 (a) Informant LILLIAN SMITH
(b) Address 1223 BATTERY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 11-46 (month) (day) (year)
(c) Cemetery or crematory BALTO NATIONAL CEM
Location BALTIMORE MD

18 (a) Funeral director Bernard E. Hanley
(b) Address 121 E West St

19 (a) (b) Registrar
(Date rec'd by registrar) JAN 10 1946

VS 15c

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 9th 1946, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946 to Jan 9 1946 and that I last saw h[illegible] alive on Jan 6 1946.

Immediate cause of death: Bilateral Lobar Pneumonia — Duration 4 days

Due to: Mitral Regurgitation — Duration Indef.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Campbell M. D.
Address 1600 Hanover St Date signed 1/9/46

Washington Williams, M.D.

G36249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

G36249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General HTP
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 East Chase Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1904

8. AGE: Years	Months	Days	If less than one day
41	7	12	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jim Arthur Hall
13. Birthplace N. C

MOTHER
14. Maiden Name ?
15. Birthplace N. C.

16 (a) Informant Mildred Hall
(b) Address 1618 E. Chase St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory
Location Pembroke, N. C.

18 (a) Funeral director Joseph L. Lockhart
(b) Address 1364 N. Central Ave

19 (a) JAN 10 1946 (Date received by registrar) Huntington Williams Registrar

VS-151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH January 8, 1946 at 8 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Occlusion of left coronary ostium

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert Lee Fentress M.D. (Medical Examiner.)
Date signed Jan. 8 1946.

G36250 — BALTIMORE CITY HEALTH DEPARTMENT — G36250

Ill. 98401

CERTIFICATE OF DEATH 92B

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4th 1923

8. AGE: Years	Months	Days	If less than one day
22	10	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Violet Washington
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Kelly
(b) Address 1303 Pleasant [illegible] Acting for Hilleary

19 (a) JAN 10 1946 (b) Registrar

Subject to approval of Medical Examiner

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th 1946 at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8th 1946 to Jan. 9th 1946 and that I last saw h er alive on Jan. 9th 1946

Immediate cause of death: Congest failure — Duration
Pulmonary Oedema
Due to Rheumatic Heart Disease
& Cardiac enlargement
Due to Mitral Stenosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None at alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T. P. Jernigan
Address Baltimore City Hosp. Date signed 1-9-46 M.D.

X

G36251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G36251
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town RFD #6 Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary F German

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife C Wm. German
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24 1896

8. AGE: Years	Months	Days	If less than one day
49	1	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Harry F Easley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Benner
15. Birthplace Baltimore

16 (a) Informant C Wm. German
(b) Address Old Harford Rd RFD #6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/46 (month) (day) (year)
(c) Cemetery or crematory Hiss Meth. Cemetery
Location Harford Road

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

JAN 10 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 1946 at 7:50 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7 Jan 1946 to 7 Jan 1946 and that I last saw h[illegible] alive on 8 Jan 1946

Immediate cause of death	Duration
Circulatory Failure	
Diab. Acidosis	
Due to Diabetes Mellitus.	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

VS 150

G36252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G36252 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd. + Herring Run
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 Belview Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS RAOUL BOURBON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-16-43

8. AGE: Years	Months	Days	If less than one day
2	10	24	hr. min.

9. Birthplace Baltimore, Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business —

FATHER
12. Name August J. Bourbon
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Gertrude May Reilly
15. Birthplace Newport News, Va.

16 (a) Informant Mother
(b) Address 4314 Belview Ave., Baltimore

17 (a) Burial (b) Date thereof January 11 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Nancy N. Arminger
(b) Address 4204 Ridgewood Ave

19 (a) JAN 10 1946 Wellington Williams, M.D.
(Date received in registrar's office) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9th, 1946, at 8:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7th, 1946, to Jan. 9th, 1946, and that I last saw him alive on Jan. 9th, 1946

Immediate cause of death	Duration
Heart Failure	
Diphtheritic Myocarditis	
Due to Diphtheria	
Due to	
Other Conditions Diphtheritic nephritis	

(Include pregnancy within 3 months of death)

Date of operation 1-7-46

Major findings of operation: Diphtheria

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stefchijo Spagnier M.D.
Address Sydenham Hosp. Date signed 1-9-46

YS 150

G36253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G36253

Type or print plainly in permanent ink. Fill in all items - please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 Pulaski Hwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Treulieb

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-16-4414

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elnora Treulieb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2 - 1888

8. AGE: Years 57 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Red Cross

FATHER 12. Name John Treulieb

13. Birthplace Baltimore

MOTHER 14. Maiden Name Elizabeth Sauerwald

15. Birthplace Baltimore

16 (a) Informant Elnora Treulieb

(b) Address 2925 Pulaski Hwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1946 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location "

18 (a) Funeral director Philip Herzig Sons

(b) Address 2024 Edgewood

19 (a) JAN 10 1946 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8- 1946 at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1946 to Jan 8 1946 and that I last saw h[illegible] alive on Jan 8 1946

Immediate cause of death Lobar pneumonia, Rhbi — Duration

Due to Organism unidentified

Due to

Other Conditions Pulmonary Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Raden M. D.

Address Sinai Hospital Date signed 1/8/46

VS 150

Huntington Williams

G36254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

G36254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2243 Mura Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2243 Mura Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad T. Geesey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03-4352

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary L. Geesey

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) aug. 30, 1890

8. AGE: Years 55 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Augustus Geesey
13. Birthplace Md

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace Md

16 (a) Informant Mary L. Geesey
(b) Address 2243 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St

19 (a) JAN 10 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1946 at 2 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry,
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarski M.D. Medical Examiner.
Date signed Jan 8, 1946

VS 151

G36255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36255 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Ryerson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Abraham Ryerson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 15, 1867
8. AGE: Years 79 | Months 1 | Days 24 | If less than one day hr. min.
9. Birthplace Philadelphia (Town, county, and state)
10. Usual Occupation Nursing
11. Industry or business

FATHER
12. Name George W. Beck
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Morrison
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Loring Byers
(b) Address 5035 Park Heights Ave.

19 (a) JAN 11 1946 (Date registered) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1946, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Jan 8 1946, and that I last saw her alive on Jan 8 1946

Immediate cause of death	Duration
Edema Lungs	2 days
Due to: Chronic Myocarditis	6 yrs
Due to:	
Other Conditions. Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North av Date signed 1/8/46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write legibly.

G36256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 / 31a

G36256 Registered No.

Please write clearly and legibly. Use ink. Do not use pencil. If cause of death is not known, so state.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 N. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Herbert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/15/1894

8. AGE: Years	Months	Days	If less than one day
51 52	8.	21	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Henry Butler
13. Birthplace Va

MOTHER
14. Maiden Name Martha Jefferson
15. Birthplace Va

16 (a) Informant Mrs Willken
(b) Address 1212 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. R. Co

18 (a) Funeral director Palmer Sanders
(b) Address 1412 E. Preston St

19 (a) JAN 10 1946 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1946, at 7½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Jan 1946, and that I last saw h[illegible] alive on Jan 6 1946

Immediate cause of death	Duration
Cardio-renal disease	
Due to	
Due to	
Other Conditions Decompensated arteriosclerotic heart disease.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Purcell M. D.
Address 1422 E Chase Date signed 1-10-46

R W. Purcell

G36257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G36257

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1654 Delano Court
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bernice Seaberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years 24 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Dunn, N. C.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Nathan Seaberry
13. Birthplace N. C.

MOTHER
14. Maiden Name Lizzie Lewis
15. Birthplace N. C.

16 (a) Informant Ira Seaberry
(b) Address 1709 Riggs Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-46 (month) (day) (year)
(c) Cemetery or crematory.....
Location Dunn, N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1019 Chantilly Ave

19 (a) JAN 10 1946 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1946 at 3:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound
of Chest

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-7-46 at 3A. M.
(b) Where did injury occur? 1654 Delano Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shooting

23. Signature Robert [illegible] Gratz, M.D.
Medical Examiner.
Date signed Jan 7 1946

VS 151

G36258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G36258 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Bethel Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Griffin Thigpen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-22

8. AGE: Years	Months	Days	If less than one day
23	10	11	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER
12. Name John Strong
13. Birthplace Md

MOTHER
14. Maiden Name Genevieve Wolk
15. Birthplace Md

16. (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (b) Date thereof 1-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Bl[illegible]

19 (a) JAN 10 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1946, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1945 to Jan 9 1946, and that I last saw h[illegible] alive on Jan 9 1946.

	Duration
Immediate cause of death: Respiratory arrest	
Due to: ? Bacterial endocarditis	
Due to: ? Brain tumor	
Due to: Rheumatic heart disease	
Other Conditions: Mitral stenosis & insufficiency	
Operation: [illegible]	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature William J. Dixon
Address Johns Hopkins Hospital 1/9/46

VS 150

G36259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No. G36259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew H. Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1868

8. AGE: Years	Months	Days	If less than one day
77	2	—	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Andrew Kraft
13. Birthplace GERMANY

MOTHER
14. Maiden Name Dorothy Kraft
15. Birthplace GERMANY

16 (a) Informant Andrew H. Kraft
(b) Address Ellicott City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 Jan 10 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1946, to 1/8 1946, and that I last saw him alive on 1/8/1946.

Immediate cause of death	Duration
Peripheral Circulatory Failure	
Due to Coronary Attack	
Due to Embolism	
Due to Arteriosclerosis	
Due to Cardiovascular disease	
Other Conditions Benign Prostatic Hypertrophy	

(Indicate pregnancy if related to cause of death)

Date of Operation 1/7/46

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Bagwell

Address Ellicott City Md. Date signed 1/9/46

VS 150

G36260 — BALTIMORE CITY HEALTH DEPARTMENT — G36260 Registrar's No.

CERTIFICATE OF DEATH 94a

Please write the causes of death clearly and legibly. Physician: Please write in capacity, important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5605 BENTON HEIGHTS AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Benton Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH A. HOCK

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife FRANK HOCK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 22 1875

8. AGE: Years	Months	Days	If less than one day
70	2	17	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name HERMAN WARMS
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant HERMAN J. HOCK (SON)
(b) Address 5605 BENTON HEIGHTS AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 11/46 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 10 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION AM

20. DATE OF DEATH JAN. 8 1946, at 10/30

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1945 to Jan. 8 1946, and that I last saw her alive on 1-8 1946.

Immediate cause of death: Coronary Thrombosis — Duration

Due to Arteriosclerosis - Cerebral

Due to Agitated Depression (Senile)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 5605 Belair Rd Date signed 1-9-46

X

G36261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36261 / 162B

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution:
Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 S. Madeira St
(If rural give location)
(e) Citizen of foreign country? Madeira (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Walburga Schnell

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	Female	White	Widowed

6 (b) Name of husband or wife FREDERICK SCHNELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 2 1854

8. AGE: Years	Months	Days	If less than one day
(F) 91	11	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name JOSEPH HONEYFELDER
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MARGARET SECAECH (FRIEND)
(b) Address 2524 BALTO. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 12/46 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Leitha Zeiler Sons
(b) Address 403 S. WOLFE ST.

JAN 10 1946 (Date rec'd by registrar) (b) Langston Williams, Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1946, at 3.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death	Duration
Terminal pneumonia	
Due to Angina & cliff duration	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Cliff Randt, M.D.
Address 3 Cogs Mans Date signed 1/10/46

G36262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36262 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2572 HOLLINS ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2572 HOLLINS ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN RITTERBUSCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife. ANNA RITTERBUSCH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 15 1895

8. AGE: Years	Months	Days	If less than one day
50	0	28	hr. min.

9. Birthplace A.A.CO MD.
(Town, county, and state)
10. Usual Occupation RETIRED POLICE OFFICER
11. Industry or business B P D

FATHER
12. Name MORITZ RITTERBUSCH
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTIMORE MD.

16 (a) Informant ANNA RITTERBUSCH (WIFE)
(b) Address 2572 HOLLINS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 12/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.
18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.
19 (a) 1946 (b) by registrar Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH JAN 7 1946, at 11/45

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to Jan 7 1946 and that I last saw h[illegible] alive on Jan 7 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	4 hr
Due to	
Due to Cerebral Sclerosis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Geary JR M. D.
Address 172 E 33rd St Date signed Jan 9/46

VS 150

G36263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36263 Registered No.

Use the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira + Linden Ave
(c) Hospital or institution: Maryland General Hospital #1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 LYNDALE AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard M Gerick

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife LAURA M. GERICK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Laura M. Gerick
(b) Address 3410 Lyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director 403 S. WOLFE ST.
(b) Address Lilly & Zeilenic

19 (a) 1-10-1946 (Date filed by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19th 1945, to Jan 9th 1946, and that I last saw him alive on Jan 9th 1946.

Immediate cause of death	Duration
Terminal pneumonia	
Due to C.V. disease & generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.E. Jamieson M.D.
Address Maryland G. Hospital Date signed 1/9/46

G36264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. G36264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 N. Patterson Park ave
(c) Hospital or institution:

8/4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 N. Patterson Park ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Dailey

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	WIDOW

6 (b) Name of husband or wife FREDERICK DAILEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 11 1875

8. AGE: Years	Months	Days	If less than one day
70 76	5	27	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ?

16 (a) Informant LILLIAN DAILEY (DAUGHTER)
(b) Address 1517 N. PATTERSON PARK AVE.

17 (a) BURIAL (b) Date thereof JAN. 11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

JAN 10 1946 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7- 1946, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Cervical Vertebrae

Due to

Other Conditions Mo treated for a heart condition at Sinai Hospital
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 8/4
(a) Date of injury 1-2- at Before 6 P. M.
(b) Where did injury occur? 1517 N. Patterson Pk Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Fell at foot of stairs

23. Signature Howard J. Wilson M.D.
Medical Examiner.
Date signed 1-8-46

VS 151

G36265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93E

Registered No. G36265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 John St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Kidd, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widow

6 (b) Name of husband or wife Naomi G. Kidd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1869

8. AGE: Years	Months	Days	If less than one day
76	4	19	hr. min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name C. Henry Kidd
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth F. Weeks
15. Birthplace Md.

16 (a) Informant Mr. William E. Kidd, Jr.
(b) Address 618 Wicklow Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 10 1946 (Date rec'd by registrar) Thurlington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1946, to Jan. 9 1946, and that I last saw him alive on Jan. 9 1946

	Duration
Immediate cause of death Cardiac - respiratory failure	
Due to Congestive heart failure	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Milton Linthicum M.D.
Address MD Mercy Hosp. Date signed 1/9/46

VS 150

G36266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G36266 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124½ W. Read St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124½ W. Read St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eugenia W. Swinton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	29	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Dobbie Wyatt
13. Birthplace S. C.

MOTHER
14. Maiden Name Julia McGurrett
15. Birthplace S. C.

16 (a) Informant Mrs. Virustine Stewart
(b) Address 1312 W. Lafayette Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-46 (month) (day) (year)
(c) Cemetery or crematory
Location Georgetown, South Carolina

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 JAN 10 1946 (Date rec'd by registrar) (b) Huntington [illegible]

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 9 1946, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 9 1946
and that I last saw h[illegible] alive on Jan 9 1946

Immediate cause of death	Duration
Arteriosclerotic Cardio Vascular Disease	1 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature] M. D.
Address 752 Preston Date signed 1/10/46

G36267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G36267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Rutter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Rutter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MILTON TEMPLE

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-4743

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1895

8. AGE: Years 50 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Temple
13. Birthplace Md,

MOTHER
14. Maiden Name Lillie Winner
15. Birthplace Md

16 (a) Informant Mrs Lillie Temple
(b) Address 1516 Rutter St.

17 (a) Burial (b) Date thereof 1 - 12 - 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem
Location Baltimore Md

18 (a) Funeral director Mrs Frances A Hemsley
(b) Address 578 N Bidde St.

19 (a) JAN 10 1946 (b)
(Date rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 9, 1946 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1945 to 1-9 1946 and that I last saw h alive on 1-8 1946.

Immediate cause of death: Carcinoma of Lungs (Bronchogenic) — Duration: 1 Year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify if special place)
(e) Means of injury

23. Signature M. D.

Address Woodlawn Maryland

Huntington Williams, M.D.

for M. L. Rutter & L. L. Anderson

536268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 536268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 E. Oliver St
(e) Citizen of foreign country? (If rural give location)
If yes, name country (Yes or No)

3 (a) FULL NAME Jillian Stormer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14th 1861

8. AGE: Years	Months	Days	If less than one day
64	3	20	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Greenbury W. Jackson
13. Birthplace Md

MOTHER
14. Maiden Name Martha Willey
15. Birthplace Md

16 (a) Informant Frank Stormer
(b) Address 2506 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11th 1946 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location E. North Ave Ext

18 (a) Funeral director Leo G. Leavy
(b) Address 1701-03 N. Patterson Park Ave

19 (Date received) JAN 10 1946 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1946 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1946, to 1-8 1946, and that I last saw her alive on 1-8 1946.

Immediate cause of death Emaciation
a Colloy death

Due to Tuberculosis - Pt apex.

Due to

Other Conditions Avitaminosis -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy the Report of Pathology.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George R Callender M. D.
Address Univ. Hosp Date signed 1-9-46

G36269 G36269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Shank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1860

8. AGE: Years	Months	Days	If less than one day
85	2	16	hr. min.

9. Birthplace Smithsburgh Md.
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Adam Shank
13. Birthplace Maryland

MOTHER
14. Maiden Name Ardra ?
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (b) Date thereof Jan. 11, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ritz Wedefeld
(b) Address 914 Greenmount Ave.

19 (a) (b) Huntington Williams
(Date rec'd by registrar) Registrar

JAN 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1946, at 12-28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2- 1946 to Jan 8 1946 and that I last saw h-r alive on Jan 8 1946

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M.D.
Address 1631 E North Ave Date signed 1/6/46

X

636270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

636270 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5203 Craig Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Craig Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Nachbar

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7 1866

8. AGE: Years 79 Months 9 Days 4 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Michael Nachbar
13. Birthplace Germany

MOTHER
14. Maiden Name Sheran Tillman
15. Birthplace Germany

16 (a) Informant Mrs. J. Hankenberg
(b) Address 5203 Craig Ave

17 (a) Burial (b) Date thereof Jan. 11, 1945
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) JAN 10 1946 (b) Registrar
(Date filed by Registrar)

Hunting for Hillcrest, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 — 8 — 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1945 to Jan 8 1946 and that I last saw h[illegible] alive on Jan 8 1946

Immediate cause of death	Duration
Arteriosclerosis	1940
Chronic Interstitial Nephritis	1941
Due to Chron Myocarditis	1940
Due to	
Other Conditions Cerebral Hemorrhage	1946

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Bishop M. D.
Address 501 S Linden Ave Date signed 1-9-46

VS 150

G36271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G36271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Cedarcroft Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) √
If yes, name country

3 (a) FULL NAME Mr. Raymond Yeakel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26 - 1900

8. AGE: Years	Months	Days	If less than one day
45	11	15	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles (dec'd)
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine (dec'd)
15. Birthplace Balto

16 (a) Informant Margaret Opatel
(b) Address 300 Cedarcroft Rd

17 (a) Burial (b) Date thereof Jan. 12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cath
Location Old Frederick Rd.

18 (a) Funeral director John A. Horan
(b) Address 4501 Government Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1946 at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1946 to 1-9 1946.
and that I last saw h[illegible] alive on 1/9 1946.

Immediate cause of death Cardiac failure — Duration

Due to Dyspnea

Due to Pt Broken Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Raiett M.D.
Address St Agnes Hosp Date signed 1/9/46

Write the causes of death clearly and legibly. Physicians: please write legibly. Important.

G36272 BALTIMORE CITY HEALTH DEPARTMENT G36272
CERTIFICATE OF DEATH
REGISTRATION NO.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Saratoga & Calvert
(b) Street address ~~Mercy Hospital~~ Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Lothian Rd
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Young Bazer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Frank Bazer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1856

8. AGE: Years	Months	Days	If less than one day
60 59			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Young
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Vineyard
15. Birthplace Md.

16 (a) Informant Mrs. Nellie Bell
(b) Address 3613 Loxley Rd

17 (a) Burial (b) Date thereof Jan 11-46
(Burial, cremation, or removal) (Month, day) (Year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Jno. A. Hogan
(b) Address 3000 E. Balto. St.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1946, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ON 19 to Jan 8 1946 and that I last saw her alive on Jan 8 1946.

Immediate cause of death	Duration
Cerebral vascular accident	2 hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature C. Milton Linthicum
Address Mercy Hosp Date signed 1/8/46
M.D.

VS 150 JAN 10 1946

Howard J. Mancini, M.D.

G36273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G36273 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mundeim & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4625 Walther Ave # 14 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul M. Siemers, Sr.

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Marie Siemers

6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) June 13th 1888

8. AGE: Years 57 | Months 6 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Internal Revenue Dept

11. Industry or business

FATHER
12. Name Herman F. Siemers
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marie Siemers
(b) Address 4625 Walther Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 JAN 10 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th 1946, at 6:39 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9th 1946, to Jan 9th 1946, and that I last saw him alive on Jan 9th 1946

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: hypertension

Due to:

Other Conditions: Diabetis mellitus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Jones Ealey

Address Maryland G. Hospital Date signed 1/9/46 M. D.

VS 150

C. J. Lubinski, by Howard D. Simmons, M.D. 830

G36274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G36274 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lafayette & John St
(b) Street address [redacted]
(c) Hospital or institution:
Hosp. for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - Middle Run
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Hampden Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillian Louise Heim.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Henry Heim.
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1908

8. AGE: Years	Months	Days	If less than one day
37	11 10	6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Home maker.
11. Industry or business

FATHER
12. Name Charles Eyg.
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Louise Polcat.
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Admission Record
(b) Address

17 (a) Burial (b) Date thereof Jan. 10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Thos. F. Connelly
(b) Address 416 Eastern Ave. Balto

19 (a) Huntington Williams, M.D.
Date rec'd by registrar Registrar

JAN 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946, at 10 20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1946, to Jan 7 1946, and that I last saw he alive on Jan 7 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	17 hrs
Due to Hypertension	1 yr
Due to Vascular Disease	
Other Conditions Rheumatic Heart Disease	20 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Hemmings M. D.
Address Hosp. for Women of Md Date signed 1-7-46

83a

36275

BALTIMORE CITY HEALTH DEPARTMENT X V G36275

CERTIFICATE OF DEATH 129

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sudbrook Medical
(c) Hospital or institution:
Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 61 Johnson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin E. Stern

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Virginia B. Stern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30 1907

8. AGE: Years 38 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Auto body builder

11. Industry or business

FATHER
12. Name Harry J Stern
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Woodbury
15. Birthplace Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (b) Date thereof 1/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Brand
Location Westminster, Md.

18 (a) Funeral director J. S. Myers Jr.
(b) Address Westminster Md.

JAN 11 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 1-10 1946 and that I last saw him alive on 1-10 1946.

Immediate cause of death	Duration
Peripheral vascular collapse	
Due to Cachexia	
Due to numerous adhesions from previous operation	
Other Conditions (gastroenterostomy)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Chronic Obstruction from numerous of autopsy: obstructing adherences

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grace R. Conlon M. D.

Address Md. General Hospital Date signed 1-10-46

VS. 150

X

36276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G36276 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3920 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15-9
(e) Length of stay in Baltimore (yrs., mos., or days): 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3920 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: David Irving Bernstein

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late MMinnie
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 75 74 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: New York City (Town, county, and state)

10. Usual Occupation:
11. Industry or business: None

FATHER
12. Name: Louis Bernstein
13. Birthplace: Russia

MOTHER
14. Maiden Name: Pauline B. Elwidge
15. Birthplace: Russia

16 (a) Informant: Mrs. Sophie Kramer
(b) Address: 5920 Norfolk Ave

17 (a): Burial (Burial, cremation, or removal) (b) Date thereof: Jan, 11, 1946 (month) (day) (year)
(c) Cemetery or crematory: Beth Tfiloh Cemetery
Location: Windsor Mill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

JAN 11 1946 Huntington Woods, Mich. (Date rec'd by local registrar)

VS 150

MEDICAL CERTIFICATION 4.A M

20. DATE OF DEATH: January 10, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945 to Jan 9 1946 and that I last saw h[illegible] alive on Jan 8 1946

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to: Myocardial failure	6 mo.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: I. Frederick Lamb M. D.
Address: Temple Garden Apt Date signed:

X

G36277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G36277

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs. 45 minutes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Alameda Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Cooke

3 (b) If veteran, name war	3 (c) Social Security Account No.
W —	NONE —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow —

6 (b) Name of husband or wife Andrew J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 1870

8. AGE: Years	Months	Days	If less than one day
75	9	13	24 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unk Coffutt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary E Coyne
15. Birthplace Balto Md

16 (a) Informant Martin J Cooney
(b) Address 2720 Alameda

17 (a) Funeral (b) Date thereof 1/12/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Fulton Corbett
(b) Address 1214 E Cold St

19 (a) JAN 11 1946 (b) Wm. Tyson Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9- 1946, at 2 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sub-dural Hemorrhage
Respiratory Failure

Due to

Other Conditions Arterial Sclerosis
Bronchial pneumonia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 1-9 at 9 a. M.
(b) Where did injury occur? 2720 Alameda Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down stairs - home at home

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 1-10-46

VS 151

G36278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G36278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3227 Abell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3227 Abell Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. D. Bedford

3 (b) If veteran, name war: NW
3 (c) Social Security Account No.: NM

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6. (b) Name of husband/wife: Annie E. Bedford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1856

8. AGE: Years	Months	Days	If less than one day
89 90	11	24	hr. min.

9. Birthplace: New York City
(Town, county, and state)
10. Usual Occupation: Hunter
11. Industry or business: Rayer Paper Co. Blair, Md

FATHER
12. Name: John R. D. Bedford
13. Birthplace: England

MOTHER
14. Maiden Name: Sarah E. Bedford
15. Birthplace: England

16 (a) Informant: Mrs. Sarah E. Wagner
(b) Address: 1611 E. North Ave

17 (a) Burial (b) Date thereof 1/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: St. Ignatius
Location: Hickory Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) JAN 11 1946 (b) [illegible] for Registrar
(Date rec'd by registrar)

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9th 1946, at 1 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Jan 9 1946 and that I last saw h[illegible] alive on Dec 26 1945

Immediate cause of death: Cardiac Insufficiency — Duration: 7.
Due to: Gen Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury,
23. Signature Samuel L. Green M.D.
Address 1701 E North Ave Date signed 1/10/46

36279 JANES ✓ 636279

AB-96878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

Please write clearly and legibly. Use one of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Clara Janes

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	10	hr. min.

9. Birthplace Wheeling, W.Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Towsend Hansen or Hanson
13. Birthplace Ohio

MOTHER
14. Maiden Name Sarah Russell
15. Birthplace W.Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Wilson & Son
(b) Address 2170 E. Fayette St.

19 JAN 11 1946 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1945, to 1-9 1946, and that I last saw her alive on 1-9 1946

Immediate cause of death Cerebrovascular accident — Duration

Due to arteriosclerosis

Due to

Other Conditions diabetes, mellitus coronary heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence / at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathon Howland M. D.
Address B.C.H. Date signed 1/10/46

VS 150

839

636280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

636280 Registered No.

Please write plainly with ink or indelible pencil. Do not use abbreviations. Make no erasures. Be sure that every question is answered. If the certificate of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 W. Bay Avenue-Brooklyn
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 W. Bay Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth F. Carlsen

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1910

8. AGE: Years	Months	Days	If less than one day
36	0	3	hr. min.

9. Birthplace Boston, Massachusetts
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Hans Carlsen
13. Birthplace Norway

MOTHER
14. Maiden Name Augusta Nelson
15. Birthplace Sweden

16 (a) Informant Mrs. A. Morris
(b) Address 3708 W. Bay Avenue, Brooklyn

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 JAN 11 1946 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 8 1946, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Jan 8 1946, and that I last saw h[illegible] alive on Jan 8 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Carlsen
Address 320 Chesapeake Date signed Jan 10/46

VS 150

G36281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered G36281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Square Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 mos 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 W Randall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert B. Everhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Stella Welch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12/23/1881

8. AGE: Years	Months	Days	If less than one day
64		19.9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Asst. Eng

11. Industry or business American Tel

FATHER
12. Name Robert Everhart
13. Birthplace Baltimore

MOTHER
14. Maiden Name Nat Watson
15. Birthplace

16 (a) Informant Mrs Stella Everhart.
(b) Address 32 W Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month), (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Rockville Md

18 (a) Funeral director J. J. Fahey Sons
(b) Address 1131 Eutaw St

19 (a) JAN 11 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/1946, at 12:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1946, to 1/11 1946, and that I last saw h[illegible] alive on 1/11 1946.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Hypertension & Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Vance M. D.
Address Franklin Square Hosp. Date signed 1/11/46

G36282 G36282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1210

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor + Dukeland
(c) Hospital or institution West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Transient

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town Bethlehem
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Maple
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Pittenger

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 171-09-4136

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nora E.

6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Feb 6 1887

8. AGE: Years: 58 | Months: 7 | Days: 10 | If less than one day: hr. min.

9. Birthplace: EAST LIVERPOOL OHIO
(Town, county, and state)

10. Usual Occupation: Accountant

11. Industry or business: Carb. Steel

FATHER
12. Name: Frank Pittenger
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Alice Eckhorn
15. Birthplace: Unknown

16 (a) Informant: Joseph H. Pittenger
(b) Address: 1810 Maple Bethlehem Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 13. 46 (month) (day) (year)
(c) Cemetery or crematory: Bethlehem Cem.
Location: Bethlehem Pa

18 (a) Funeral director: Odell Funeral Home Inc.
(b) Address: 4624 York Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/46 19 .. at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 19 46 to 1/10 19 46, and that I last saw h.. alive on 1/10 19 46

Immediate cause of death: Cardiac Failure
Uremia — Duration:
Due to Hypertensive Cardio Vas Renal Dis. Arteriosclerosis
Due to Nephro Sclerosis
Other Conditions Prostatic Carcinoma
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lesley A. Hall Jr. M. D.
Address Sloan + Bates Gen Hosp Date signed 1/10/46

VS 150

G36283 Leave #1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#170c

G36283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. 0 m.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 60? | Months | Days | If less than one day: hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation ..

11. Industry or business ..

FATHER
12. Name Unknown
13. Birthplace ..

MOTHER
14. Maiden Name ..
15. Birthplace ..

16 (a) Informant ..
(b) Address ..

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JAN 10 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1945, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull Fracture.
Intracerebral Hemorrhage.
Due to Compound fracture of left leg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5:35 P. at 12-5-45 M. 5-2
(b) Where did injury occur? Orleans St. 30 ft. west of Exeter St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Auto

23. Signature Benedict Shitarelli M.D.
Medical Examiner.
Date signed December 6, 1945.

VS 151

636284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

636284 Registered No. 108

Type or use ink. Fill all items. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age if apparently important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves.
(c) Hospital or institution: St Agnes Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Teresa Draper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife George E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1924

8. AGE: Years 21 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, or state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Frank Bizzarri

13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Manley

15. Birthplace West Va

16 (a) Informant Husband George E. Draper

(b) Address 1012 Hollins Street

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore Bell Co.

Location 5581 Pedigrist Ave.

18 (a) Funeral director John J Conway & Son

(b) Address 1003 Hollins Street

19 (a) (Date rec'd by registrar) (b) Registrar's No. 8

JAN 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1946, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1946, to 1/10 1946, and that I last saw h[illegible] alive on 1/10 1946.

Immediate cause of death

Thrombosis

Due to Bilateral Pneumonia

Due to

Other Conditions Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Calvert, Jr M.D.

Address St Agnes Hosp Date signed 1/10/46

G36285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Keene Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Alice A.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 17, 1867

8. AGE: Years 78 | Months 6 | Days 23 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gas & Electric Co.

FATHER
12. Name Henry C Bell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lenora Harris
15. Birthplace Baltimore, Md.

16 (a) Informant Mr Harrison M. Arnold
(b) Address 604 Stamford Rd. Ten Hills

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Road

18 (a) Funeral director John J Bowen & Son
(b) Address 901-03 Hollins St.

19 (a) JAN 11 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946, at 3 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due To Carbon Monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 9th 1946 1:30 P.M.
(b) Where did injury occur? 3612 Keene Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas from stove

23. Signature Robert L. Forbes M.D.
Medical Examiner.
Date signed Jan 9 1946

G36286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. G36286

Please write the causes of death clearly and legibly. Physicians: please write in capital letters.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5009 Ardmore Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
or Street No. 5009 Ardmore Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES H. HEDRICK

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	212-03-4533	Male	White	Married

6 (b) Name of husband or wife Ethel R. Hedrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1910

8. AGE: Years	Months	Days	If less than one day
35	6	10	hr. min.

9. Birthplace Freeland, Md. (Town, county, and state)
10. Usual Occupation Office Manager
11. Industry or business Sherwin Williams Co.

FATHER
12. Name Irvin R. Hedrick
13. Birthplace Freeland, Md.

MOTHER
14. Maiden Name Annie E. Hunt
15. Birthplace Freeland, Md.

16 (a) Informant Mrs. Ethel R. Hedrick
(b) Address 5009 Ardmore Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Signature of local registrar) (b) Registrar

JAN 11 1946

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Jan. 8, 1946 at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1945 to 1-8 1946 and that I last saw h[illegible] alive on 1-8 1946

	Duration
Immediate cause of death: Pulmonary embolism	8 hrs.
Due to Bacterial endocarditis	1 mo.
Due to Staphylococcus Septicemia (recovered in hospital)	Wor. Dec'd 1 mo.
Other Conditions Hemiplegia (Cerebral embolism) (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation: Blood & Sp. Fluid cultures pos. for Staph: neg. to Penicillin	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W Madden
Address 6304 Belair Rd. Date signed 1/9/46 M. D.

X

G36287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G36287 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Willow av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 704 Willow av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes name country

3 (a) FULL NAME Mary M. Price

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anthony P. Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17-1870

8. AGE: Years 75 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albert Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Seiss
15. Birthplace France

16 (a) Informant Anthony P. Price
(b) Address 704 Willow av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rood.
Location Baltimore Md.

18 (a) Funeral director John. A. Logan
(b) Address 4501 Greenmount av

19 (a) Filed [illegible] 1946 Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Jan 9 1946 and that I last saw h[illegible] alive on Jan 9 1946

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to Cerebral Hemorrhage	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 115 E Eager St Date signed 1/10 46 M. D.

VS. 150

X

636288 BALTIMORE CITY HEALTH DEPARTMENT 636288

CERTIFICATE OF DEATH 935

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 N. Charles Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frederick P. Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875?

8. AGE: Years	Months	Days	If less than one day
70?			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name J.D. Kremelberg
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Deford
15. Birthplace Balto. Md

16 (a) Informant H. M. Jenkins Son & Reed
(b) Address McCulloh Orchard Sts

17 (a) Cremation (b) Date thereof Jan 12 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Green Mount Cem
Location Balto., Md.

18 (a) Funeral director Henry M. Jenkins Son &
(b) Address McCulloh & Orchard Sts.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

VS-15

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10-1946, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 1-10-46

G36289 BALTIMORE CITY HEALTH DEPARTMENT G36289

CERTIFICATE OF DEATH

6 ✓

Registrar's No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delaney Calaman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-4-41

8. AGE: Years	Months	Days	If less than one day
4 5	9	5	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Stewart Calaman
13. Birthplace Md

MOTHER
14. Maiden Name Ophelia Bryant
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Hea. H. Kelson
(b) Address 1302 Pleasant St.

19 (a) JAN 11 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Jan. 9 1946, at 9.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1946, to 1/9 1946, and that I last saw him alive on 1/9 1946.

Immediate cause of death Meningococcemia — Duration

Due to

Due to

Other Conditions Shock

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Blair Everett Bolton M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 1/9/46

VS 150

X

G36290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

G36290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Ft.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Gavaghan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife Elizabeth Hancock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1867

8. AGE: Years	Months	Days	If less than one day
78 Yrs	10	2	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name John Gavaghan
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret McGill
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1946 (month) (day) (year)
(c) Cemetery or crematory Alandale
Location Georgia

18 (a) Funeral director Rella Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

JAN 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-10- 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8- 1946, to Jan 10- 1946, and that I last saw h[illegible] alive on Jan 10- 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Cerebral arterio-Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Bill Hall
Address 1631 E. North av Date signed 1/11/46 M. D.

File the causes of death clearly and legibly. Physicians please write.

G36291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G36291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 N. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer R. Wingrove Jr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-05-1878

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian M. Wingrove

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-23-89

8. AGE: Years 56 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Supt. Tel Co.

11. Industry or business (Traffic Dept.)

FATHER 12. Name Thomas R Wingrove

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary E. Cady

15. Birthplace Balto., Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JAN 11 1946 (b) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946 at 3.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1945 to Jan. 9 1946 and that I last saw him alive on Jan. 9 1946

Immediate cause of death: Pulmonary Embolism — Duration

Due to: Thrombosis in femoral vein

Due to

Other Conditions: Bladder tumor

(Include pregnancy within 3 months of death)

Date of operation 1-4-46

Major findings of operation: Writers - Sigmoid anastamosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Moorhouse M. D.

Address Johns Hopkins Hosp Date signed 1-10-46

VS 150

G36292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G36292 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 132 days
(e) Length of stay in Baltimore (yrs., mos., or days) 132 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County
(c) City or town Chicago
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4554 N. Springfield Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Keefe, Patrick John

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Miller
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	21	hr. min.

9. Birthplace Clinton, Iowa
(Town, county, and state)
10. Usual Occupation Pipefitter
11. Industry or business

FATHER
12. Name Patrick Keefe
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgett Mc Nealey
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Jan 14-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Millwaukie & Chicago
18 (a) Funeral director Odell Funeral Home Inc.
(b) Address 4644 Vincennes
1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1946, at 2:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1945 to Jan. 11 1946, and that I last saw him alive on Jan. 11 1946

Immediate cause of death Carcinoma of left lung with metastasis to heart. Gangrene left lower lobe. — Duration UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 1/11/46
US Marine Hospital, Balto, Md.

VS 150

Huntington Williams, M.D.

G36293 ✓ G36293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. 1

Please write plainly. Use ink. Report one cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland
(c) Hospital or institution:
West Baltimore Gen. Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give township)
(d) Street No. 403 N. Payson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charlotte Odendhal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Baby.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/1944

8. AGE: Years	Months	Days	If less than one day
1	1	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Harry M. Odendhal
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clarice Cunningham
15. Birthplace Marion, Ohio

16 (a) Informant Mrs Clarice Odendhal
(b) Address 403 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director Frederick A. Cole
(b) Address 1600 W. Lombard

19 (a) JAN 11 1946 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 January 1946, at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Jan 1946, to 9 Jan 1946, and that I last saw h.e.x alive on 4 Jan 1946

Immediate cause of death Resp. Failure — Duration

Due to Pulmonary Edema, Etc.

Due to Diarrhoea, Etio. unDet. Tetany

Other Conditions Convulsive Seizures

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leslie O. Stacey Jr.
Address B. C. H. Date signed M. 1 D. 9 1946

VS 150

G36294 BALTIMORE CITY HEALTH DEPARTMENT ✓ G36294

CERTIFICATE OF DEATH 47

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 FLEET ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 FLEET ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK H.HARMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife KATHERINE HARMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG.29 1878

8. AGE: Years	Months	Days	If less than one day
67	4	10	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation CORE MAKER
11. Industry or business

FATHER
12. Name CHARLES HARMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name CATHERINE WITHIG
15. Birthplace GERMANY

16 (a) Informant KATHERINE HARMAN (WIFE)
(b) Address 2217 FLEET ST.

17 (a) BURIAL (b) Date thereof JAN. 12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.
18 (a) Funeral director Lilly & Geiselmann
(b) Address 403 S. WOLFE ST.
19 (a) (b) Huntington Williams
(Date received by registrar)

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH JAN. 8 1946 at 11/30

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Jan 8 1946 and that I last saw h[illegible] alive on Jan 8 1946.

Immediate cause of death
Myocarditis
Pulmonary Carcinoma (1) (?)
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

Duration
Unc
6 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Leo J. Lipsky M. D.
Address 1378 Patterson Pk. Ave. Date signed 1/10/46

VS 150

G36295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G36295 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens ave & Caton
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 321 S. Collins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Burkett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ada A. Dougherty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1905

8. AGE: Years	Months	Days	If less than one day
41	-	8	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Radio Mechanic
11. Industry or business Capitol Radio Service

FATHER
12. Name Charles Burkett
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Christopher
15. Birthplace Maryland

16. (a) Informant Mrs. Ada Burkett
(b) Address 321 S Collins Ave

17 (a) Burial (b) Date thereof 1-14-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H Witzke
(b) Address 4101 Edmondson Ave.

19 (a) JAN 11 1946 Washington Williams M.D.
(Date received by registrar) (Registrar's signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1946 at 25 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 1-11-46

G36296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G36296 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 607 S. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur B. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Norville Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1894

8. AGE: Years 51 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Sup. Rt. Cleaning Dept

11. Industry or business Balto. City

FATHER
12. Name William Smith
13. Birthplace Ohio.

MOTHER
14. Maiden Name Mary E. Daniel
15. Birthplace Ohio.

16 (a) Informant Mrs. Mary Smith
(b) Address 607 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Rd.

18 (a) Funeral director Harry H. Wetzler
(b) Address 410 Edmondson Ave

19 (a) JAN 9 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 1946 at 9:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ ~~(Strike out one)~~ the causes of death were:

IMMEDIATE CAUSE OF DEATH Penetrating Bullet wound of right temple

Due to Involving brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8 January 1946 11:45 P M.
(b) Where did injury occur? Carroll Park Tennis Court
(c) Did injury occur at home, on farm, industrial place, in public place? In public place While at work?
(d) Means of injury Self inflicted Gun Shot Wound

23. Signature Willard B. Helfrich M.D. Medical Examiner.
Date signed 9 January 46

G36297 G36297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Glenarm Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Glenarm Avenue (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME James C. Williams

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara Noah
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 25, 1861

8. AGE: Years	Months	Days	If less than one day
84	5	15	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Alexander Williams
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanor Longley
15. Birthplace Maryland

16 (a) Informant Mrs. James E. Hand
(b) Address 4506 Glenarm Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director John F Henry Inc
(b) Address 714 Bright St.

19 (a) ..... (b) .....
(Date rec'd by registrar) (Registrar)

JAN 14 1946
VS 45M 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1946 at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic
cardiovascular disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 10 1946

G36298 ✓ G36293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4521 Mainfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4521 Mainfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob E. Ellwanger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola C. Covey
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	13	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Ellwanger
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown Hyde
15. Birthplace Pa.

16 (a) Informant Mrs. Viola Ellwanger
(b) Address 4521 Mainfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/46 (month) (day) (year)
(c) Cemetery or crematory Concord Cem.
Location Concord, Md.

18 (a) Funeral director John F. Flemming Inc.
(b) Address 1116 Light St.

19 (a) JAN 11 1946 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1946, at 8 40 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skaradic M.D.
Medical Examiner.
Date signed 1-10-46

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36299 ✓ G36299 144a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write legibly, important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 E. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Deitz S33298

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Harry A. Deitz

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) 9/27/1905

8. AGE: Years 40 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Housewife (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Dells
13. Birthplace Md.

MOTHER
14. Maiden Name Estella —
15. Birthplace —

16 (a) Informant Harry A. Deitz
(b) Address 105 E. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director John F. Dempsey, Inc.
(b) Address 716 Light St.

19 (a) (Date rec'd by registrar) JAN 11 1946 (b) Registrar Winston Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946 at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1945 to Jan 9. 1946. and that I last saw her alive on Jan 9 1946.

Immediate cause of death CARDIAC INSUFFICIENCY — Duration

Due to COLAMBIA CHRONIC NEPHRITIS

Due to over

Other Conditions Pregnancy - 8 mo gestation ? Possible Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hamp T. Wilson Jr. M. D.
Address St. Josephs Hosp. Date signed 9 Jan 46

X

G36300 — BALTIMORE CITY HEALTH DEPARTMENT — G36300

CERTIFICATE OF DEATH

131a

Registered No.

Correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 E. Randall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Ellsworth Wenger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Amelia Wenger
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1890

8. AGE: Years	Months	Days	If less than one day
55	3	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Tanning Operator
11. Industry or business

FATHER
12. Name Anthony Wenger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ella Wenger
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Amelia Wenger
(b) Address 10 E. Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Ritchie Highway

18 (a) Funeral director Fred A. Krahns & Son
(b) Address 1216 S. Charles St.

19 (a) JAN 11 1946 (Registrar) (b) Filed by Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1946, at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-1 1945 to 1/10 1946, and that I last saw h alive on 1/9 1946.

Immediate cause of death	Duration
Pneumonia	
Myocarditis —	
Due to Arteriosclerosis	
Due to Hypertension —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Brumbaugh M. D.
Address 1111 Lee Date signed 1/11/46

VS 150

G36301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G36301 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age in carefully important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1250 E.North Avenue
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1250 E.North Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J.Dudley

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Elizabeth G.Foley
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) July 29th, 1878

8. AGE: Years 67 | Months 5 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Elect.Dept Balto;City

FATHER
12. Name Christopher Dudley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Coulter
15. Birthplace Baltimore, Md.

16 (a) Informant Miss.Agnes M.Dudley
(b) Address 1250 E.North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Ritchie Hwy.Balto;Co

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan.9th, 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 6 1946 to JAN 9 1946 and that I last saw h(IM) alive on JAN 8 1946

Immediate cause of death: Coronary artery occlusion — Duration 3 days
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature Howard Schumacher
Address 1101 N Wheeler Ave Date signed 1-9-46 D.

VS 150

G36308 — BALTIMORE CITY HEALTH DEPARTMENT — G36308

CERTIFICATE OF DEATH

93c

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as specially important. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Dudley Avenue
(c) Hospital or institution:

26

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Dudley Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August J. Boerschel

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	216-03-6671

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Monica C. McLean
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1905

8. AGE: Years	Months	Days	If less than one day
40	3	0	### hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Kavanaugh Products

FATHER
12. Name Paul A. Boerschel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Walter
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Monica C. Boerschel
(b) Address 3402 Dudley Avenue

17 (a) Burial (b) Date thereof 1/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9th., 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1946 to Jan 9 1946, and that I last saw h[illegible] alive on Jan 5 1946.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to Rheumatic-Cardio-Vascular Disease	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Hunsefort M.D.
Address 1401 Eutaw Pl Date signed 1/10/46

VS 180

G36303 — BALTIMORE CITY HEALTH DEPARTMENT ✓ — G36303 Registered No.

CERTIFICATE OF DEATH 94a

Type or print plainly in black ink. Do not write over dotted lines. Be sure to answer every question. If none, write none. Use extra paper if necessary. Be sure to give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5402 Narcissus Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5406 Narcissus Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calbert R. Wells

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Grace F. Wells Ford
6 (c) If alive, give age 1898 years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1892

8. AGE: Years	Months	Days	If less than one day
47	0	22	..... hr. ..... min.

9. Birthplace Calvert Co., Maryland
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Store

FATHER
12. Name William M. Wells
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Agnes Land
15. Birthplace Calvert Co., Maryland

16 (a) Informant Grace F. Wells
(b) Address 5406 Narcissus Ave

17 (a) Burial (b) Date thereof 1-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Harmony
Location Owings, Calvert Co., Md.

18 (a) Funeral director Thomas Rivera
(b) Address 505 Park Heights Ave

19 (a) JAN 11 1946 (b) Arrington-Williams Mortuary
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1945 to 1/9 1946 and that I last saw h... alive on 1/4 1946

Immediate cause of death Coronary (Occlusion) Thrombosis
Due to Coronary artery disease
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Duration
Date
10/22/45

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Starfas M.D.
Address 5106 Park Heights Ave Date signed 1/10/46

Starfas M.D.

G36304 × ✓ G36304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Oakland
(c) Hospital or institution: East Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Old Joppa Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma Grover Grove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	married

6 (b) Name of husband ~~or wife~~ Charles Wm.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19-1914

8. AGE: Years	Months	Days	If less than one day
31	3	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name George W. Connell
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine E. Ward
15. Birthplace

16 (a) Informant Mrs. Charles W. Grove
(b) Address 2621 Old Joppa Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd. Thurgood Mortuary

19 (a) (Person who furnishes data) (b) Registrar

JAN 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 January 1946, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Jan 1946 to 10 Jan 1946 and that I last saw h.e. alive on 10 Jan 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Miliary Tuberculosis	
Due to	
Laryngeal TBC	
Other Conditions 1 Day Post Partum	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester A. Straeter M. D.
Address E. B. D. Hosp. Date signed 1/10/46

X

G36605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Cleveland
(c) Hospital or institution: Mt Berto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Old Joppa Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Boy Grove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-46

8. AGE: Years [redacted] Months Days 2 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Charles W. Grove
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Rommel
15. Birthplace Md.

16 (a) Informant Mrs. Charles Grove
(b) Address 2621 Old Joppa Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-46 (month) (day) (year)
(c) Cemetery or crematory Edgewood
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by local reg.) (b) Washington Williams M.D. Registrar

JAN 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946, at 4:42 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Jan 1946 to 11 Jan 1946 and that I last saw h[illegible] alive on 11 Jan 1946

Immediate cause of death Respiratory Failure — Duration

Due to Atelectasis

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis H. Grove Jr. M. D.
Address Mt Berto Gen Hosp Date signed 1/11 1946

Write legibly. Especially important. Physicians: please write the causes of death clearly and legibly.

JL - 8236.06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Correct age in typewritten important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 5 - 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5414 Cerland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rita F. Maenner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles P. Maenner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1918

8. AGE: Years	Months	Days	If less than one day
27	4	28	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name J. Herbert White
13. Birthplace Md.

MOTHER
14. Maiden Name Emma B. Kalista
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Kuhl
(b) Address 535 Hanford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 11 1946

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death
Renal Tuberculosis
Pulmonary Tuberculosis

	Duration
Due to	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Gerland Jr. M.D.
Address Balt. City Hosp. Date signed 1/10/46

Baker

G36307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36307 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rockdale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Milford Mill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Lee Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Oscar F. Baker
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) November 1884

8. AGE: Years	Months	Days	If less than one day
61	2 1	?	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Chilcoate
13. Birthplace United States

MOTHER
14. Maiden Name Mary Cole
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Robert C. Baker
(b) Address 3716 Milford Mill Road, Rockdale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Hampden, Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 4510 Liberty Heights Ave.

19 (a) 1 1 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1946, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945 to Jan 9 1946, and that I last saw h- alive on Jan 9 1946

Immediate cause of death [illegible]
Cerebral Vasc. accident — Duration 17 days
Due to
Due to
Other Conditions Hypostatic Pneumonia
(Include pregnancy within 3 months of death)
Date of operation O
Major findings of operation:
of autopsy: O

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. A. Weiner M. D.
Address Univ. Hosp Date signed 1-9-46

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36508 (Registered No.)

Please write the causes of death clearly and legibly. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Carlview
(d) Street No. 4504 Carlview Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie R Gray
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: R. Walter Gray
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) Dec 12th 1879
8. AGE: Years 66 | Months - | Days 26 29 | If less than one day ... hr. ... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: James C. Roseberry
13. Birthplace: Kent County, Md.

MOTHER
14. Maiden Name: Edwina Kelly
15. Birthplace: Kent County, Md.

16 (a) Informant: Mrs. Ralph Schley
(b) Address: 4504 Carlview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: Miller Lawrence
(b) Address: 4510 Liberty Heights Ave.

19 (a) ... (b) ... (Date rec'd by registrar) Huntington Williams, M.D.

JAN 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/46 1946, at 5:44 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946, to Jan 10th 1946, and that I last saw her alive on Jan 9th 1946

Immediate cause of death	Duration
Terminal pneumonia	
Due to Parkinson disease	
Due to CVD disease + generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. E. Gonzalez, M. D.
Address Maryland General Hospital Date signed 1/10/46

VS 150

please write the causes of death clearly and legibly. Physicians:

G36309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G36309

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Frey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			2 hr. 30 min.

9. Birthplace Univ. Hosp. Balto Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name David B. Frey
13. Birthplace

MOTHER
14. Maiden Name Betty Waltemeyer
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School

18 (a) Funeral director
(b) Address

JAN 12 1946
(Date rec'd by registrar)

Commissioner of Health
Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946 at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1946 to 1/7 1946 and that I last saw him alive on 1/7 1946.

Immediate cause of death	Duration
Premature birth - 2 lbs.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature A. Robert Mark M. D.
Address Univ. Hosp. Date signed 1/7/46

VS 150

3214

X

G36310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1604

Registered No. G36310

Write the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution:
17+1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 938 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Dueen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	B	—

6 (b) Name of husband or wife Pearl Dueen
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Jan 1-46

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Robert Dueen
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Pearl Harris
15. Birthplace Balt. Md.

16 (a) Informant Pearl Dueen
(b) Address 938 Argyle Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 12 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Jan 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19....

Immediate cause of death Unk.

Due to Unk.

Due to Unk.

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. L. Strayer M. D.
Address Univ. Hosp. Date signed

VS 150

3213

G36311

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 119a

G36311 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Katherine Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/45

8. AGE: Years	Months	Days	If less than one day
	1	5429	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Della Jones
13. Birthplace Va.

MOTHER 14. Maiden Name Leona Jackson
15. Birthplace Va

16 (a) Informant Leona Jackson
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School JAN 12 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 12 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1946 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1946 to 1-4 1946, and that I last saw h.C.K alive on 1-4 1946.

Immediate cause of death Acidosis — Duration

Due to Diabetes

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George K. Gallagher M. D.
Address Univ. Hosp. Date signed 1-4-46

VS 150

3212

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104a

G36312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Wilkens alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (d) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1945

8. AGE: Years — | Months 1 | Days — | If less than one day hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation unemployed.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Princess Lytle
15. Birthplace ? S.C.

16 (a) Informant Princess Lytle
(b) Address Rock Hill, S.C.

17 (a) Burial (b) Date thereof 1-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Lemmon Hill Ave

19 (a) (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

JAN 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7- 1946 at 8:32 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uppr Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 1-8-46

G36313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. G36313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. General Hosp. 1?
(d) Length of stay in hospital or inst. (yrs., mos., or days) Boa
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 W. Hoffman st. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ernest Watson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) -1899

8. AGE: Years 47 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Watson
13. Birthplace Va.

MOTHER 14. Maiden Name Annie Fitzgerald
15. Birthplace Va.

16 (a) Informant Pearl Justice
(b) Address 206 - N. Chester Ave. Baltimore Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-12-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location Adolphus Halstead

18 (a) Funeral director
(b) Address 918 - Reid Hill Ave

19 (a) ..... (b) .....
(Date rec'd by registrar)

JAN 12 1946

VS 154

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1946 at 1 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho pneumonia bilateral.

Due to.....

Other Conditions Biliary cirhosis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Benedict Waterlee M.D. Medical Examiner.
Date signed 1-9-46

107

G36314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Hyde Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 16 Box 349 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Thomas James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Jefferson James

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-20

8. AGE: Years 25 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Thomas

13. Birthplace ?

MOTHER 14. Maiden Name Sarah Acree

15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Hobelbal

(b) Address 918 Edmondson Ave.

19 (a) (Date filed by registrar) Lexington Williams (Registrar)

JAN 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1946, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1946 to 1-8 1946 and that I last saw h alive on 1-8 1946.

Immediate cause of death	Duration
Tuberculous meningitis	
Due to Miliary tuberculosis of Lungs	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Johns Hopkins Hosp Date signed 1-13-46

Physician: please write the causes of death clearly and legibly. Correct age is especially important.

G36315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G36315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 W. Mt. Vernon Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2952 Wyman Park Dr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Morley Hoag M. D.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Eugenie Hoag
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7-1875

8. AGE: Years	Months	Days	If less than one day
71		3	hr. min.

9. Birthplace Canada
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name James Hoag
13. Birthplace Canada

MOTHER
14. Maiden Name Lucinda Hunter
15. Birthplace Canada

16 (a) Informant R. W. Hammerslough
(b) Address 11 W. Mt. Vernon Place

17 (a) Burial (b) Date thereof 1/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Filed JAN 12 1946 (b) Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10-1946 at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy and Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 1-11-46

G36316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57D

Registered No. G36316

Please answer questions clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 S. Essex Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hubert J. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 210-05-2260

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-79

8. AGE: Years	Months	Days	If less than one day
66	2	4	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Williams Construction Co

11. Industry or business Carpenters Helper

FATHER 12. Name Jacob Thomas

13. Birthplace Pa.

MOTHER 14. Maiden Name Rachel Benson.

15. Birthplace Pa.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Ext Rd

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) Date received by local registrar JAN 12 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1946 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1945 to 1-11 1946 and that I last saw h. alive on 1-11 1946

Immediate cause of death: NEOPLASM, LEFT CEREBRUM, TYPE UNDETERMINED — Duration: 3 MONTHS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. L. Asper M. D.

Address Johns Hopkins Date signed Jan 9, 1946

636317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

636317 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1242 N Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1242 N Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Galuska

3 (b) If veteran, name war no
3 (c) Social Security Account No. 217-14-6975

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 85 | Months | Days | If less than one day: hr. min.

9. Birthplace Hungary
(Town, county, and state)
10. Usual Occupation Tailor (Retired)
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Galuska
(b) Address 1242 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Lord Gay
(b) Address 1217 E Fayette St

19 (a) 1-12-1946 (b) Huntington Williams M.D.
(Local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1946, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9- 1946, to Jan 11 1946, and that I last saw him alive on Jan 10- 1946.

Immediate cause of death — Duration

Cerebral Hemorrhage — 2 days
Due to Arteriosa Sclerosis — 6 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Av Date signed 1/11/46

G36318 G36318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

CWK-83376

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 4- 19-
(e) Length of stay in Baltimore (yrs., mos., or days) 90- 3- 6-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 19
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Forrester

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Emma (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4-1855

8. AGE: Years	Months	Days	If less than one day
90	3	6	hr. min.

9. Birthplace Maryland Avenue
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jos Forrester
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Biddison
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lawrence J. Funeral Home
(b) Address 7401 Belair Road

19 JAN 12 1946 (Date received by registrar) (b) Washington Williams (Registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH January 10 1946 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 21 1945 to Jan. 10 1946, and that I last saw h in alive on Jan. 10 1945.

Immediate cause of death	Duration
Lobar pneumonia	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B-H Date signed 1/11/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANCIS C. MURPHY

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-03-3648

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Laura M. Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1888

8. AGE: Years	Months	Days	If less than one day
57	5	27	hr. min.

9. Birthplace Springfield, Mass. (Town, county, and state)
10. Usual Occupation Pressman
11. Industry or business News Post

FATHER
12. Name John T. Murphy
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Mary E. McKernan
15. Birthplace Mass.

16 (a) Informant Mrs. Laura M. Murphy
(b) Address 2111 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Data entered by registrar) (b) Registrar

JAN 12 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Jan 10 1946 and that I last saw h[illegible] alive on Jan 9 1946

Immediate cause of death: Chronic Cardio Vascular disease — Duration 1½ hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest H. Kalm M. D.
Address 1735 Park Ave Date signed 1/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G36320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G36320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N. Bond
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman Tarleton

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Huckster
11. Industry or business

FATHER
12. Name William Tarlton
13. Birthplace Md.

MOTHER
14. Maiden Name Nellie Tarlton
15. Birthplace Md.

16 (a) Informant Nellie Tarlton
(b) Address 25 N. Durham st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

JAN 12 1946 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan 8 1946 and that I last saw h. alive on Jan 8 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis	All 7 wks
Due to Dt. Femur	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Fisher M. D.
Address 642 W Monument Date signed 1-9-46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1190

Registered No. G36321

Please write the causes of death clearly and legibly. Physicians: please write the correct age as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Durham (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Williams ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-23-45

8. AGE: Years | Months: 8 | Days: 16 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter Williams
13. Birthplace NC

MOTHER 14. Maiden Name Flores Coppage
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Wilson

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantley ave
JAN 12 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1946 at 10 32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan 9 1946 and that I last saw him alive on Jan 9 1946.

Immediate cause of death: Dehydration — Duration:
Due to: Diarrhea — 2 days
Due to: Unknown
Other Conditions: Anemia, rickets
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter M Tasen M. D.
Address J H H Date signed 1-10-46

VS 150

X

G36322
75744 CWK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G36322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore 3m 8m 6m (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Albert Renehan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22-1864

8. AGE: Years	Months	Days	If less than one day
81	7	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Renehon
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Machoy
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave. Catonsville

19 (a) JAN 12 1946 (b) Easton Williams Mgr
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 19 45, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 19 44 to Jan. 10 19 45, and that I last saw him alive on Jan. 10 19 45.

Immediate cause of death coronary occlusion? — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B < H Date signed 1/10/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36323

BALTIMORE CITY HEALTH DEPARTMENT

HB# 98310

CERTIFICATE OF DEATH 181

G36323

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 144 N. Haven St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Keeley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Keeley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years	Months	Days	If less than one day
56 ?			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation General Laborer
11. Industry or business

FATHER
12. Name ? James Keeley
13. Birthplace? Baltimore

MOTHER
14. Maiden Name ? Martha Brown
15. Birthplace ? Baltimore

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Co.
Location City

18 (a) Funeral director Kelly & Funeral Home
(b) Address 2008 Orleans St

19 (Date received) JAN 1 2 1946 Registrar Wittington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10, 1946, at 3:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1946 to Jan. 10 1946 and that I last saw h im alive on Jan. 10, 1946

Immediate cause of death: Bronchopneumonia, Bilateral — Duration: 5 Days

Due to 2° & 3° Burns Chest, Upper Extremities, Neck, — Duration: 6 Days

Due to HAND FACE

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation JAN 5, 46
Major findings of operation: 2° & 3° Burns of Chest, Upper Left, Neck & Face.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence JAN 5, 46 at 7:00 A M
(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury BURN from Stove

23. Signature Hugh E. Kellerville M. D.
Address Baltimore City Hosp. Date signed Jan. 10, 46

Thomas J. Mancini, M.D.

VS 150

G36324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G36324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Elsinor Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Elsinor ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie M Wilhelm

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Wm H Wilhelm
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept 30 1880

8. AGE: Years	Months	Days	If less than one day
65	3	10	hr. min.

9. Birthplace Wicomico Co Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Thos Calloway
13. Birthplace Somerset Co Md

MOTHER
14. Maiden Name Martha Freeney
15. Birthplace Wicomico Md

16 (a) Informant Wm H Wilhelm
(b) Address 2603 Elsinor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) Filed by Registrar (b) JAN 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10th 1946 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Jan 10 1946 and that I last saw her alive on Jan 10 1946.

Immediate cause of death	Duration
Carcinoma of Sigmoid	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer U. Todd M. D.
Address 2108 St Paul St Date signed 1/11/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G36325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution:
Hospital For the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Belair Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hospital For Women of Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bowman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1946

8. AGE: Years	Months	Days	If less than one day
—	—	—	— hr. 47 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Dewey Fleet Bowman
13. Birthplace Aberdeen, Md

MOTHER
14. Maiden Name Laura Anne Hood
15. Birthplace Mt. Airy, Md.

16 (a) Informant Dewey Fleet Bowman
(b) Address Belair, Md.

17 (a) Removal (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY JAN 10 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 11 1946 Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1946 at 3 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 45 P.M. Jan 7, 1946 to 3 15 P.M. Jan 7 1946, and that I last saw h.i. was alive on Jan 7, 1946.

Immediate cause of death Congenital Atelectasis, Bilateral — Duration —

Due to Prematurity — Duration 25 min

Due to ?

Other Conditions Fusion of 3rd & 4th toes, bilaterally
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. D'Paula M. D.

Address Hospital For Women of Md. Date signed 1/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36326 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 Harford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Harford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary I. Ogden (Mollie)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 18 1856

8. AGE: Years 89 | Months 9 | Days 22 | If less than one day: 4 hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Home Work at
11. Industry or business Home

FATHER
12. Name George R. Ogden
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Elizabeth Bowen
15. Birthplace Calvert Co. Md

16 (a) Informant Mrs. Susanna Burbage
(b) Address 1002 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Friends Burial Ground
Location Harford Rd near 25 Ft.

18 (a) Funeral director Elmer W. Cookelin & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar Wilmington for Williams

JAN 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1946, at 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 1/10 1946 and that I last saw h[illegible] alive on 1/10 1946.

Immediate cause of death	Duration
(a) Lobar Broncho Pneumonia	
Due to (b) Ch. Myocardial disease	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Augusta St Date signed 1/11/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G36327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G36327

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1250 S. Elwood Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1250 S. Elwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Name No)
If yes, name country

3 (a) FULL NAME John M. Kitko

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Rose M. Kitko (maiden name)
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1 Nov. 1894

8. AGE: Years 51 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Glazier-Painter
11. Industry or business Window Glass Business

FATHER
12. Name Stephen Kitko
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Stach
15. Birthplace Austria

16 (a) Informant Mrs. Rose M. Kitko
(b) Address 1250 S. Elwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14 46 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Germany Hill Road

18 (a) Funeral director: Stephen J. Fialkowski
(b) Address 1000 S. Kenwood Ave

19 (a) JAN 12 1946 (Date rec'd by registrar) (b) Huntingtn for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Jan. 1946 at 3.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1946 to Jan 10 1946 and that I last saw him alive on Jan 10 1946

Immediate cause of death: Cerebral Hemorrhage — Jan 7 — | Duration: 1946
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward J. Stechman M. D.
Address 3505 Eutaw Date signed Jan 11, 46

G36328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36328 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 866 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter E. Webner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1886

8. AGE: Years	Months	Days	If less than one day
60 +	8	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dr. Henry W. Webner
13. Birthplace Penna.

MOTHER
14. Maiden Name Florence Jenkins
15. Birthplace Md.

16 (a) Informant ?
(b) Address

17 (a) Burial (b) Date thereof 1/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bureal
Location London Park

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul st

19 (a) (b)
(Date rec'd by registrar) (Registrar)

VS/H1 JAN 12 1946 Washington Nilsen

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1946, at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry; find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sudbrake M.D.
Medical Examiner.
Date signed 1/9/46

G36329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G36329

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 72 Dundalk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna A. Hill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Franklin E. Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1893

8. AGE: Years: 52 | Months: 3 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: House-wife

11. Industry or business

FATHER 12. Name: Richard A. Plowman
13. Birthplace: Maryland

MOTHER 14. Maiden Name: Ella Becker
15. Birthplace: Alaska

16 (a) Informant: Franklin E. Hill
(b) Address: 72 Dundalk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14 1946 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore - Md

18 (a) Funeral director: Maynard D. Covington
(b) Address: 21 W. 25th St.

19 JAN 12 1946 (b) Huntington Williams, M.D. Registrar
Date received by Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1946, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946, to 19..., and that I last saw her alive on Jan 10 1946

Immediate cause of death	Duration
Cerebral Hemmorrhage	9 hrs
Due to: Hypertension (Essential)	
Due to:	
Other Conditions: Cardiac decomp.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Samuel Wiener M. D.
Address: Univ. Hosp. Date signed 1-10-46

VS 150

G36330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36330 Registered No. 4747

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 E. Madison
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Davis

3 (b) If veteran, name war –
(c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Married

6 (b) Name of husband or wife William Davis
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 30th 1904

8. AGE: Years	Months	Days	If less than one day
41	5	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Davis
(b) Address 1021 E. Madison St.

17 (a) Burial (b) Date thereof 1-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Bogert Mamis & Wright
(b) Address 721 Cathedral St

19 (a) [illegible] (b) Huntington Williams M.D.
(Signature of Registrar)

JAN 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1946, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1946, to Jan. 8 1946 and that I last saw her alive on Jan. 7 1946.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease,	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lightstone M. D.
Address 2129 Druid Hill Ave. Date signed 1/9/46

X

G36331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 N. Loudon Ave.
(c) Hospital or institution: ********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ******
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 N. Loudon Ave.
(If rural give location)
(e) Citizen of foreign country? ******** (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. thor STRATEN

3 (b) If veteran, name war

3 (c) Social Security Account No. 176-05-3820

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Minnia Straten

6 (c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.) 6/27/1885

8. AGE: Years 60 | Months 6 | Days 14 | If less than one day ******** hr. ******** min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Accountant

11. Industry or business: Small War Plant Corp.

FATHER
12. Name: S.J.thor Straten
13. Birthplace: Denmark

MOTHER
14. Maiden Name: Emma Kromm
15. Birthplace: Maryland

16 (a) Informant: Mr. Allan C. Driver
(b) Address: 2812 N. Loudon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: ~~H. G. Bohlert & Son~~
(b) Address: 1300 Eutaw Place.

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

JAN 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ------- 1943 to Jan. 11 1946 and that I last saw him alive on Jan. 10, 1946

Immediate cause of death	Duration
Coronary occlusion and myocardial infarction.	12 hrs.
Due to: Coronary sclerosis.	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: None.

Major findings of operation:

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Ira E. Bayer M. D.
Address: 11 East Chase Street Date signed

Dr. Ira. E. Bayer
0900-1100 Hr.

Please write the causes of death clearly and legibly. Physicians: please write correct age if especially important. Use only supplied blanks.

G36332 Bendler

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G36332 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Hamilton (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Southern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Bendler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-46. 8 25/60

8. AGE: Years	Months	Days	If less than one day
			hr. 10 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frederick Charles Bendler

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary Wentz Watson

15. Birthplace Baltimore Md.

16 (a) Informant Frederick C. Bendler

(b) Address 3603 Southern Ave

17 (a) Burial (Burial, cremation, or Removal) (b) Date thereof 1/12/46 (month) (day) (year)

(c) Cemetery or Crematory Geo. Calleander

Location Baltimore Md

18 (a) Funeral director F. J. Wiesheyer Son

(b) Address 300 Eutaw Place

19 (a) (Registrar's signature) (b) Huntington Williams, M.D.

JAN 12 1946

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1946, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8:35 A.M. 1/11 1946, to 8:45 A.M. 1/11 1946, and that I last saw him alive on 1/11 1946.

Immediate cause of death	Duration
Congenital Atelectasis	10 Minutes
Due to Prematurity	
Due to Spontaneous abortion	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. Stichel Jr. M. D.

Address Bon Secours Hosp. Date signed 1/11/46

X

G36333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G36333 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in every instance. Information should be satisfactory to Registrar. Cause of death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3835 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3835 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Schmidt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Louis Schmidt
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 9/30/1866
8. AGE: Years 79 Months 3 Days 12 If less than one day hr. min.
9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Robal
13. Birthplace Hungary

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Elizabeth Schmidt
(b) Address 3835 Wilkens Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Mount Hebron Cemetery
Location Baltimore Md
18 (a) Funeral director J. A. Nappent & Son
(b) Address 300 Lutrow Street
JAN 12 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1946, at 12:55 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1943 to Jan 11 1946, and that I last saw h[illegible] alive on Jan 10 1946.

Immediate cause of death: Cerebral Thrombosis — Duration 5 days
Due to: Generalized arterio-sclerosis — 3yrs?
Due to:
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None —

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Earl Pass, M.D.
Address 4001 Wilkens Ave Date signed 1-11-46

2802 Harford Rd

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G36534

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Abbottston, St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Abbottston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Estelle Mc Nally

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Charles P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5- 1881

8. AGE: Years	Months	Days	If less than one day
64	10	6	hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John A. Connelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose A. Cusack
15. Birthplace Md.

16 (a) Informant Mr. Charles P. McNally
(b) Address 1513 Abbottston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

JAN 12 1946 (Date rec'd by registrar) (Signature) Forrest Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11- 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16-1943 to 1-11-1946 and that I last saw her alive on 1-10-1946.

Immediate cause of death	Duration
Arteriosclerotic cardio renal disease	Unknown
Due to Diabetes	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Lybert M. D.
Address 1802 Harford Rd Date signed 1-12-46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

C36335 Dr. Davis

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 186a

Registered No. C36335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos. or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3227 Tyndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no

3 (a) **FULL NAME** Samuel R. James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name ~~of husband or~~ wife Sarah E. James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 77 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-45 (month) (day) (year)
(c) Cemetery or crematory
Location Parkwood Cemetery

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N. Broadway

JAN 12 1946

(b) [illegible] Huntington Williams, M.D.

VS 150 for S. J. R. Davis, by Howard J. Nuttle, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1946, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1945, to Jan 10 1946, and that I last saw h[illegible] alive on Jan 10 1946

Immediate cause of death	Duration
Hypostatic Pneumonia	4 days
Due to	
Fracture of left femur	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec. 15 1945 M
(c) Where did injury occur? Balto. Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall down stairs

23. Signature Thos. E. Wheeler M. D.
Address South Balto Gen. Hosp. Date signed 1/10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G36336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Wicklow Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Wicklow Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROWLAND JESSE BAUM

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 216-10-3665

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Madeline Baum
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 12, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	29	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Lucas Brothers

FATHER
12. Name Frederick S. Baum
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Tevenian
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Ethel M. Baum
(b) Address 624 Wicklow Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 12 1946 (Date rec'd by registrar) (b) Mailing for Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1946 at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stefanelli M.D.
Medical Examiner.
Date signed 1-16-46

X

636337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

636337 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Issac Shetzer

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5710

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1889

8. AGE: Years	Months	Days	If less than one day
56		17	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Jailor

FATHER
12. Name Harry Shetzer
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs Bessie Shetzer
(b) Address 2915 Parkwood Ave

17 (a) Burial (b) Date thereof Jan. 13, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Filed 1946 Harrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1946 at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Subrosky M.D.
Medical Examiner.
Date signed 1/14/46

VS 151

G36338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G36338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Beechland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. McGee

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret M. McGee
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1897

8. AGE: Years 48 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Phila., Pa.
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name Harry J. McGee
13. Birthplace N. J.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Margaret M. McGee
(b) Address 2817 Beechland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Wm. McG. John M. Tuffel & Son
(b) Address 801 N. Fayette St

19 (a) (Date received by registrar) (b) Registrar

JAN 13 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1946, at 3:30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1945 to 1/11 1946, and that I last saw him alive on 1/11 1946.

Immediate cause of death Terminal: Pneumonia — Duration 2 days

Due to Bronchiogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Some

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 1/11/46

Correct ages is especially important. Physicians: please write the causes of death clearly and legibly.

G36339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G36339 Registered No.

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 3312 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 W Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter James Evans

3 (b) If veteran, name war	3 (c) Social Security Account No.
None.	None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married.

6 (b) Name of husband or wife Margaret J. Evans
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1866

8. AGE: Years	Months	Days	If less than one day
79	6	3	hr. min.

9. Birthplace Ewell - Maryland.
(Town, county, and state)
10. Usual Occupation Sea Food Business.
11. Industry or business Oyster Boats.

FATHER
12. Name Solomon Evans.
13. Birthplace Ewell - Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Ewell - Md.

16 (a) Informant Mrs. Margaret J. Evans
(b) Address 3312 W Franklin St.

17 (a) Removal Burial (b) Date thereof Jan 14-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ewell Methodist Cem.
Location Ewell - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 505 N. Monroe St.

19 (a) (Date received by registrar) (b) Registrar

JAN 13 1946
OS 1ST

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1946, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Colbrook M.D.
Medical Examiner.
Date signed 1/12/46

G36340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

G36340
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the exact age is especially important. The

1. PLACE OF DEATH: Union memorial Hospital
(a) Baltimore City, Maryland
(b) Street address ,
(c) Hospital or institution: Union memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 E. Joppa Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrick Whiting Pullen, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Myrick W. Pullen, 6 (c) If alive, give age years
maiden name?

7. Birth date of deceased (mo., day, yr.) 1/25/1883

8. AGE: Years	Months	Days	If less than one day
62	11	10/16	hr. min.

9. Birthplace Iowa
(Town, county, and state)
10. Usual Occupation Professor at John Hopkins University
11. Industry or business

FATHER
12. Name Malden B. Pullen
13. Birthplace Maine

MOTHER
14. Maiden Name Julia E. Whiting
15. Birthplace Alabama

16 (a) Informant Mrs. Julia S. Pullen
(b) Address 1511 E. Joppa, Rd. Towson

17 (a) Burial (b) Date thereof 1/14/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location York Rd. Towson, Md

18 (a) Funeral director Howard A. Gill
(b) Address 19 W. Penna. Ave. Towson, Md.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

JAN 13 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/1946, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946, to Jan 10 1946, and that I last saw him alive on Jan. 10 1946

Immediate cause of death Pulmonary embolism — Duration

Due to

Due to

Other Conditions Hemiplegia, left arm.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: infarction L. lung, LL

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kirkpatrick, Jr. M.D.
Address Union Memorial Hosp. Date signed 1/10/46

G36341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36341 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd, Stuart & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Apts., Lake Dimmick Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Florence Heart (Florence) (Florence K. Heart)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Widowed

6 (b) Name of husband or wife Isaac J. Heart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1870

8. AGE: Years	Months	Days	If less than one day
75	10	9	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation 0
11. Industry or business

FATHER
12. Name Adolph Koenigsberger
13. Birthplace Germany

MOTHER
14. Maiden Name Rosa Rosenbaum
15. Birthplace Germany

16 (a) Informant Mrs. Eli Heart
(b) Address Cylburn Court Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/46 (month) (day) (year)
(c) Cemetery Hebrew Friends Hgs
Location Balto. Md.

18 (a) Funeral director David Sandhirsch & Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 13 1946 Hunting for Hollander, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1946 at 9:18 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/1946, to 1/12/1946, and that I last saw her alive on 1/11 1946,

Immediate cause of death	Duration
Arteriosclerotic heart disease,	
Chronic decompensation	
Due to arteriosclerosis generalized	
Due to	
Other Conditions Cerebral hemorrhage left. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Speed M.D.
Address Union Mem. Hosp. Date signed 1/13/46

X

G36342 3044 East Lyndhurst G36342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3044 Stafford
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 Stafford St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F Pant

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Bessie Mae
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4. 1874

8. AGE: Years	Months	Days	If less than one day
71.	4	8	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Benjamin —
13. Birthplace Md

MOTHER 14. Maiden Name Margt J Thompson
15. Birthplace Md.

16 (a) Informant Bessie Mae
(b) Address 3044 Stafford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edward Loudon
(b) Address 233 Gwynn Oak Blvd

19 (a) [illegible] for Huntington Williams, M.D.
(Date received) Registrar

JAN 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1946 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 1/12 1946 and that I last saw h[illegible] alive on 1/12 1946.

Immediate cause of death Hypertensive heart disease — Duration 2yr

Due to

Due to

Other Conditions Acute uremia — 3 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 Wilkens Ave Date signed 1/12/46

G36343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G36343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. Hosp. 1828 W. Saratoga (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald B Burrows

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30, 1945

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Balt. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Earl J. Burrows
13. Birthplace W. Va.

MOTHER
14. Maiden Name Rowena Killian
15. Birthplace W. Va.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Jan 14 1946 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director E. A. Farley
(b) Address 1809 W. Fayette St

19 (a) (b) Huston Wilkinson Registrar
(Local registrar) M.D.

JAN 13 1946

VS 151

MEDICAL CERTIFICATION 35

20. DATE OF DEATH January 12, 1946 at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraiser M.D. Medical Examiner.
Date signed Jan. 12 1946

G36344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G36344 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3533 White Chapel Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3533 White Chapel Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Rubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia.

MOTHER
14. Maiden Name Lena
15. Birthplace Russia

16 (a) Informant Lena Boobol
(b) Address 3533 White Chapel Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmen
Location Ferncliff Rd. Ph.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) Date received 1-13-1946 (Date registrar received certificate) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12- 1946 at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1946 to Jan. 12 1946 and that I last saw him alive on Jan. 12 1946

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor D. Fry M.D.
Address 3322 Eastern Pkwy Date signed 1/13/46

VS 199

G36345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

G36345 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 Warren ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Warren Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Annie Elizabeth Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1875

8. AGE: Years 70 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Crisfield, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas J. Conner
13. Birthplace Crisfield Md

MOTHER
14. Maiden Name Annie E Handy
15. Birthplace Crisfield, Md.

16 (a) Informant Mrs Flora Pruett
(b) Address 307 Warren ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16 1946 (month) (day) (year)
(c) Cemetery or crematory Crisfield Md
Location Crisfield, Md

18 (a) Funeral director Howard Hubbard
(b) Address Crisfield Md

JAN 14 1946 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to January 13 1946, and that I last saw h. alive on January 12 1946

Immediate cause of death Hypertensive Cardiovascular Disease — Duration 15 yrs
Arterial Enlargement
Due to Tenth Left Ventricular failure — 3 wks
Due to Cerebral Hemorrhage — 4 d
Other Conditions Coma & Paralysis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Earl Pass, M.D.
Address 1001 Widens Ave Date signed 1-13-46

J. Earl Pass

G36346

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G36346

CERTIFICATE OF DEATH 107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2023 W. Fayette St.
(b) Street address Bon Secours Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Bedford Hills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Anthony H. Mathieu

3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Jessie Morse Mathieu
6 (c) If alive, give age # years

7. Birth date of deceased (mo., day, yr.) June 1 - 1872

8. AGE: Years 73 | Months 7 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER
12. Name Dr. Ferdinand C. Mathieu
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Bosse
15. Birthplace Baltimore, Md

16 (a) Informant Carl Mathieu
(b) Address 381 E 21st St. Brooklyn

17 (a) Burial (Burial, Cremation, Removal) (b) Date thereof Jan-17-46 (month) (day) (year)
(c) Cemetery Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas R Evans & Son
(b) Address 118 W. Mt Royal Av

(Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 196

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/1946, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29/1945 to 1/11/1946, and that I last saw h[illegible] alive on 1/11/1946

Immediate cause of death: Circulatory collapse — Duration 12 hrs

Due to: Adynamic ileus — 5 days

Due to: Bronchopneumonia — 2 wks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide N/A
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Strickland Jr M. D.
Address Bon Secours Hosp Date signed 1/11/46

Write the causes of death clearly and legibly. Physicians: please write the exact age is especially important. [illegible]

G36347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1340 Registered No. G36347

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Jarrettsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elmer Durham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of ~~husband~~ wife Virginia Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1881

8. AGE: Years	Months	Days	If less than one day
61	6	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name William Durham
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Ford
15. Birthplace Maryland

16 (a) Informant Elmer Durham
(b) Address Jarrettsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 46 (month) (day) (year)
(c) Cemetery or crematory Jarrettsville
Location Jarrettsville Harford Co

18 (a) Funeral director Martin Gehrdt
(b) Address Jarrettsville Md.

19 (a) JAN 14 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13/1946, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29/1945, to 1/13/1946 and that I last saw him alive on 1/13/1946

Immediate cause of death	Duration
Cardiac decompensation	
Due to Uremia	
Due to Renal Calculi Nephrolithiasis	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. W. Baggett M. D.
Address Jarrettsville Md. Date signed 1/14/46

VS 150

G36348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G36348
Registered No. 436348

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Use ink.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 E. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) of 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Silas Luder Frizzell

3 (b) If veteran, name war

3 (c) Social Security Account No. no work

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8- 1880

8. AGE: Years	Months	Days	If less than one day
65	2	5	hr. min.

9. Birthplace Westminster - Carroll Co. Md.
(Town, county and state)

10. Usual Occupation Carpenter

11. Industry or business Building business

FATHER
12. Name Levi Frizzell
13. Birthplace Westminster - Md

MOTHER
14. Maiden Name Anna Rebecca Barber
15. Birthplace Westminster - Md

16 (a) Informant Roy Frizzell
(b) Address 28 31 Wilkins Av.

17 (a) Burial (b) Date thereof Jan. 17 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18 (a) Funeral director H. Bankard & Son
(b) Address Westminster, Md.

19 (a) Date rec'd JAN 14 1946 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13th 1946 at 10A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1945, to Jan. 13 1946, and that I last saw h alive on Jan. 12 1946

Immediate cause of death Carcinoma of Prostate Gland — Duration 2 yrs

Due to — Duration 10 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Jon Edermatt M.D.

Address 1136 Poplar Grove St. Date signed 1/13/46

G36349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109a

Registered No. G36349 (G36347)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Maine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Maine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley F. Cieslak

3 (b) If veteran, name war

3 (c) Social Security Account No. 191-01-2669

4 Sex: Male

5 Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M Cieslak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25 1908

8. AGE: Years 37 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Checker Mill

11. Industry or business Bethlehem Steel Co

FATHER
12. Name John Cieslak
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Anna M Cieslak
(b) Address 4301 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 17 1946 (month) (day) (year)
(c) Cemetery or crematory St Michaels
Location Dubois Pa

18 (a) Funeral director Harry F Thompert
(b) Address 4204 Pulaski Hwy

19 (a) JAN 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1946, at 1.9. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946, to Jan 13 1946, and that I last saw him alive on Jan 10 1946.

	Duration
Immediate cause of death: Lobar Pneumonia	6 D.
Cardiac failure	2 D.
Due to: Fibroid Ventricular Fibrillation	4 H.
Due to: Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Koons M.D.
Address 1202 Eutaw St Date signed Jan 13/46

E. W. Koons

G36350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G36350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 E. 26th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 E. 26th Street
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Evelyn May Monosmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1908

8. AGE: Years	Months	Days	If less than one day
37	1	11	---hr. ---min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name John W. Monosmith
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Justina B. May
15. Birthplace Baltimore, Maryland

16 (a) Informant John W. Monosmith
(b) Address 2 E. 26th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) JAN 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1946, to Jan. 11 1946, and that I last saw her alive on Jan. 10 1946

Immediate cause of death Acute tuberculosis — Duration 6 Days

Due to

Due to

Other Conditions Chronic Nephritis Incomplete Abortion
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry B. Athey M. D.
Address 2204 St. Paul St. Date signed 1/12/46

H. B. Athey, M.D. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

36351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. G36351

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Co. 28
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Overbrook Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Montgomery
3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-5313
4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Marie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 12. 1911

8. AGE: Years	Months	Days	If less than one day
34	4	-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Civil Engineer
11. Industry or business Shipbuilding Ship Yard
FATHER 12. Name Robert Montgomery
13. Birthplace Md
MOTHER 14. Maiden Name Grace Rosenbrock
15. Birthplace Md
16 (a) Informant Marie Montgomery
(b) Address 407 Overbrook Rd Catonsville
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md
18 (a) Funeral director Pulhorn Bros Inc
(b) Address 1211 Cathedral St.
19 (a) Date rec'd (by Registrar) Interring for Williamsport

JAN 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946, at 9:10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1946 to 1-12 1946, and that I last saw him alive on 1-12 1946.
Immediate cause of death Cardiac - Resp failure — Duration
Due to Acute Pulmonary Edema
Due to Acute Glomerular Nephritis
Other Conditions Uremia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas E Carr Jr MD
Address St Agnes Hosp. Date signed 1/13/46

636352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87C

636352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Sanders St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Sanders St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Hodgson Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary Jackson Hodgson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1863

8. AGE: Years 82 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William Hodgson
13. Birthplace Scotland

MOTHER
14. Maiden Name Sarah Eaglson
15. Birthplace Unknown

16 (a) Informant George W. Hodgson
(b) Address 423 Sanders St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15th 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 14 1946 (Date received by registrar) (b) Interred for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12th 1946, at 8 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1943 to Jan 12th 1946, and that I last saw him alive on 1/10 1946.

Immediate cause of death Auralgia Agitans

Due to

Due to

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Calhoun ave Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G36353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W Hinkley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Lena McDougal

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Fem'l | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow Married

6 (b) Name of husband or wife: James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7. 1899

8. AGE: Years 47 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Attendant Tavern

11. Industry or business

FATHER
12. Name Camillo DiLuca
13. Birthplace Italy.

MOTHER
14. Maiden Name Julia M Catlett
15. Birthplace Baltimore Md

16 (a) Informant Mr Frank Liberto
(b) Address 826 Allendale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Catholic
Location Baltimore Md

18 (a) Funeral director Tillman & Co Inc
(b) Address 1211 E Pont St

19 (a) JAN 14 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1946, at 7 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1946 to 1-11 1946 and that I last saw her alive on 1-11 1946.

Immediate cause of death Acute blood loss
Hemorrhage
Due to Oesophageal varix
Due to Cirrhosis of liver
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George R Callender M. D.
Address Union Hosp Date signed 1-11-46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G36354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G36354

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Baulding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Marion

6 (c) If living, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22 1896

8. AGE: Years 49 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Washington D.C (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Linon
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name ? Arnold
15. Birthplace Wash D.C.

16 (a) Informant Ethelyn Sklar
(b) Address Pittsburgh Pa

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

JAN 14 1946 (Date rec'd by Registrar) Hamilton for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-46 19 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9- 1946 to 1-12 1946 and that I last saw her alive on 1-11- 1946.

Immediate cause of death Cardiac failure — Duration
Immediate cause
Due to Hypertensive Arteriosclerotic cardio vascular disease
Due to Congestive failure Azotemia Nephrosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kurt W Baldwin M.D.
Address West Baltimore General Hospital 1/12/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G36355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 353 Rosebank Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 74 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 353 Rosebank Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME: Hannah Shepherd Ward

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years: About 82 | Months: --- | Days: --- | If less than one day: -- hr. --- min.

9. Birthplace: Liverpool, England (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: ------

FATHER
12. Name: Not obtainable
13. Birthplace: England

MOTHER
14. Maiden Name: Not obtainable
15. Birthplace: England

16 (a) Informant: Mrs. L. Alan Dill
(b) Address: 24 Whitfield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: H. W. Meares and Son
(b) Address: 805 N. Calvert Street

19 JAN 14 1946 (b) [illegible] (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1946 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Jan 11 1946.
and that I last saw h[illegible] alive on Jan 11 1946.

Immediate cause of death — Duration
(a) Bronchial Pneumonia — 5 days
Due to: (b) Infirmities of Age — [illegible]
Due to: (c) Funeral arrangements delayed — [illegible]

Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1-12-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G36356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Clement St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Clement St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Helen Masakowska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1882

8. AGE: Years 63 64 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Grzybowski
13. Birthplace Poland

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Walter Masakowski
(b) Address 1612 Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15, 1946 (Month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore

18 (a) Funeral director F. H. Ozgarowski
(b) Address 1930 Eastern Avenue

19 (a) (Date received by Registrar) (b) Registrar

JAN 17 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1946 to Jan 11 1946 and that I last saw h. alive on Jan 10 1946

Immediate cause of death: Mitral Regurgitation Pneumonia — Duration 5d.

Due to Arteriosclerosis — 5d.

Due to Cer. Hemorrhage Nephritis — 5d.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. H. Stevens M. D.

Address 878 Hanford Date signed 1-12-46

G36357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G36357 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1052 William St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1052 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Fenning

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-10-5730

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Calara Dreland.
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1886

8. AGE: Years	Months	Days	If less than one day
59 61	4	9	hr. min.

9. Birthplace New York State
(Town, county, and state)
10. Usual Occupation Incinerator
11. Industry or business Balto City Eng.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Calara Fenning
(b) Address 1052 William St.

17 (a) Burial (b) Date thereof 1/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Newark, N.J. N.J.

18 (a) Funeral director John J. Henry Inc.
(b) Address 714 Light St.
(c) Huntington Williams M.D.
(Date received) (Registrar) Registrar

JAN 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/46 19 at 9.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22/1944 to 1/10 1946 and that I last saw h[illegible] alive on 1/9 1946

Immediate cause of death Malignancy of lungs following metastases from carcinoma of prostate. — Duration 1 yr. 10 mos.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Cecil
Address 1226 Hanover St Date signed 1/10/46

correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

VS 150

G36358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G36358 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 3609 Callaway Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3609 Callaway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie C. Jenkins

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arthur N. Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1886

8. AGE: Years 59 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Allison
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Nettie Strong
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Arthur N. Jenkins
(b) Address: 20 W. Redwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md. Baltimore Co.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pennsylvania Aves.

19 (a) (Date received by registrar) JAN 14 1946

Hunting for Hilbert

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/46 19 , at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 11 1946, and that I last saw h her alive on Jan 10 1945

Immediate cause of death: Carcinoma of Brain — Duration: 2 mos.

Due to: General Carcinomatosis. P. Lung removed 8 June/45 — Duration: a yr.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature W. B. Summers and Kerr M. D.
Address 2200 Jamesville Blvd Date signed 1/12/46

X

G36359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G36359 Registered No.

1. PLACE OF DEATH: 33rd Street
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5214 Springlake Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Hicks (Frances M.) FRANCES MAY HICKS
3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Richard T. Hicks
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) February 18, 1872
8. AGE: Years 73 | Months 10 | Days 28 21/23 | If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation home
11. Industry or business

FATHER
12. Name Mr. Price Oman
13. Birthplace Virginia

MOTHER
14. Maiden Name Matilda Love
15. Birthplace Virginia

16 (a) Informant Mrs. Hugh Norman Hicks (Son)
(b) Address Same

17 (a) Entombment (b) Date thereof Jan. 14-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn-Maryland

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (R.F. [redacted]) [redacted] Harford Avenue

19 (a) (b)
(Signature and address)

JAN 14 1946
VS 150

Thurlington for Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 10 1946, to January 11 1946, and that I last saw her alive on January 10 1946.

Immediate cause of death: arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Seppelman
Address Harford Union Memorial Hospital Date signed 1/11/46
M. D.

X

correct age is especially important. Physicians: please write the

G36360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G36360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 N Broadford St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 N. Broadford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Grubert Sr

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-16-9117

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11th 1876

8. AGE: Years 70 | Months - | Days - | If less than one day hr. min.

9. Birthplace Md
(Town, county and state)

10. Usual Occupation Night Watchman

11. Industry or business Drug Dairy

FATHER
12. Name George M. Grubert Sr
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Brahmann
15. Birthplace Germany

16 (a) Informant Mr. Grubert
(b) Address 1715 N Broadford St

17 (a) Burial (b) Date thereof Jan 14th 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave Cem

18 (a) Funeral director Leo B. Lesser
(b) Address 1101-03 N. Pattison Park Ave

19 (a) (b)

Date received JAN 14 1946 Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11th 1946, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1945 to Jan 11 1946, and that I last saw h alive on Jan 10 1946.

	Duration
Immediate cause of death myocardial infarction	1 hr.
Due to coronitis -	?
myocarditis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Schlicht

Address 447 N. Kenwood Ave Date signed 1/14/46

Huntington for Wilson

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G36361

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 E. Lafayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Normagle Bradshaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/26/45

8. AGE: Years	Months	Days	If less than one day
	4	17	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Kennard Bradshaw
13. Birthplace N.C.

MOTHER
14. Maiden Name Pauline Harding
15. Birthplace N.C.

16 (a) Informant Kennard Bradshaw
(b) Address 400 E Lafayette Ave

17 (a) Burial (b) Date thereof Jan 17 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Dgt.
(b) Address 1127 N. Gaurine St.

19 (a) JAN 14 1946
(Date rec'd by registrar)

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14-1946 at 11 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Asphyxiation due to aspiration of milk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 1/12/46 12/5

(a) Date of injury 1/12/46 at 10 P. M.
(b) Where did injury occur? 400 E. Lafayette Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? ---
(d) Means of injury Aspiration of milk

23. Signature Benedict Stitardis M.D.
Medical Examiner.

Date signed 1-12-46

Huntington Hospital

(over)

X

G36362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

Registered No. G36362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 - N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annette Joyner

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-12-7134

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Black	Married (Separated)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1895

8. AGE: Years	Months	Days	If less than one day
50	11	27	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Truck Woman (Laborer)
11. Industry or business Penn. R.R.

FATHER
12. Name Thomas Ottums
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Lainter
15. Birthplace Va.

16 (a) Informant Irene Gadsney
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Jan. 15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Buckroe Va.

18 (a) Funeral director Mrs. Robert A. Elliott & Daughter
(b) Address 1129 N. Carlin's St.

19 (a) (b) Huntington Williams M.D.
(Signature of registrar) Registrar

JAN 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1946 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1946 to 1-11 1946 and that I last saw h.. alive on 1-11 1946.

Immediate cause of death Uremia — Duration

Due to Hypertensive CV Disease

Due to ? Chronic Glomerulo nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas D. Stephens M. D.
Address Johns Hopkins Hosp. Date signed 1-12-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 94a

G36363 Registered No.

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2. Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Rosedale Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Babilow Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret McNeal

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Geo. L. McNeal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1881

8. AGE: Years 64 | Months 10 11 | Days 17 19 | If less than one day hr. min.

9. Birthplace Balto Co (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frederick Stellman

13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Smith

15. Birthplace Germany

16 (a) Informant Mr. Geo. L. McNeal

(b) Address 411 Babilow Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14 46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location Bpo. Md

18 (a) Funeral director Philip Sterling Sons

(b) Address 2024 Eutaw St

19 (a) Received this record JAN 14 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1946, at 9.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1945, to 1-11 1946, and that I last saw h[illegible] alive on 1-11 1946

Immediate cause of death Septicemia

Due to Pyelitis

Due to

Other Conditions Hypertension Myocardial degeneration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley Ray Steinbach M. D.

Address Sinai Hospital Date signed 1-12-46

Huntington Williams, M.D.

133a

G36364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

Registered No. G36364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
General German aged People Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Eckhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband or wife Nate Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1864

8. AGE: Years	Months	Days	If less than one day
81	2	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John H. Pausch
13. Birthplace Pa.

MOTHER
14. Maiden Name Frederick Bauer
15. Birthplace Germany

16 (a) Informant Mrs. J. Geo. Walz
(b) Address 22 S. Athol Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14/46 (month) (day) (year)
(c) Cemetery or crematory Loraine Pk.
Location Woodlawn, Md.

18 (a) Funeral director Harry A. Tuttle
(b) Address 401 E Lanvale Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 14 1946

Va 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10/46. 19 , at 7.55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3/45 19 to Jan. 10/46. , and that I last saw her alive on Jan. 9/45 19

Immediate cause of death	Duration
Chronic Endocarditis Unknown.	
Due to	
Due to	
Other Conditions Chronic Unknown. Parenchymatous Nephritis. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nevels Owens M. D.
Address 933 Hawn. Date signed Jan 12/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36365 ✓ G36365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6621 Fairdel Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6621 Fairdel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband late Henry L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1861

8. AGE: Years	Months	Days	If less than one day
84	2	3	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name August Schraedetzke
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Volz
15. Birthplace Germany

16 (a) Informant Frederick A George
(b) Address 6621 Fairdel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Henry H Wilhelm
(b) Address 4107 Edmondson Ave

19 (a) JAN 14 1946 (Date rec'd by registrar) (b) Clayton Williams M.D. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Jan 10 1946, and that I last saw her alive on Jan 10 1946.

Immediate cause of death Uterine Carcinoma — Duration 1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence unknown at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Gorfy M.D.
Address 5106 Harford Rd M. D. Date signed 1-12-46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly.

G36366 — BALTIMORE CITY HEALTH DEPARTMENT — G36366

CERTIFICATE OF DEATH 479

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 South Kenwood Ave
(c) Hospital or institution: Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 S. Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Petty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 1879 — June 16

8. AGE: Years	Months	Days	If less than one day
66	11	27	hr. min.

9. Birthplace Fort Sill, Oklahoma (Town, county, and state)

10. Usual Occupation Lumber Inspector

11. Industry or business

FATHER
12. Name Charles Petty.
13. Birthplace —

MOTHER
14. Maiden Name Helen Hilde
15. Birthplace ?

16 (a) Informant Mrs. Minnie Petty
(b) Address 802 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15, 1946. (month) (day) (year)
(c) Cemetery or crematory Oakland Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director John J. Linda
(b) Address 2021 Hudson St.

19 (a) Date rec'd by Reg. (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945, to Jan 2 1946, and that I last saw h[illegible] alive on Jan 12 1946.

Immediate cause of death	Duration
Carcinoma of Rectum	1945
Cerebral Hemorrhage	1946
Due to Hypertension	1945
Diabetes Mellitus	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Abelman M. D.
Address 3505 Dale Ave Date signed 1/14/46

VS 150

X

Dr. Anthony Thomas
Old Cold Spring & 4600 York Road

G36367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G36367

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 East 39th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 East 39th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth S. Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William Becker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1870

8. AGE: Years	Months	Days	If less than one day
75	6	22 21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christian ?
13. Birthplace Germany

MOTHER
14. Maiden Name Susan Schoel
15. Birthplace Germany

16 (a) Informant: Mrs. Marie Mc Cullough
(b) Address 504 East 39th Street-18-

17 (a) Burial (b) Date thereof 1/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 14 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1946 at 3 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 1-12 1946, and that I last saw her alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	Sudden
Due to Hypertensive Cardio vascular renal disease	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas M. D.
Address 4600 York Rd Date signed 1-17-46

Huntington Williams, M.D.

X

G36368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G36368 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE BLACK INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HOWARD A. LIST

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	wh.	M

6 (b) Name of husband or wife MARY ELLEN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1907

8. AGE: Years	Months	Days	If less than one day
38	10	29	hr. min.

9. Birthplace Balto - Md (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Glenn L. Martin

FATHER
12. Name William G. List
13. Birthplace ✓

MOTHER
14. Maiden Name Lillian Monroe
15. Birthplace ✓

16 (a) Informant Mrs - Mary Ellen List
(b) Address 1508 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- 46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) JAN 14 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12- 1946, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1946 to Jan 12 1946, and that I last saw him alive on Jan 12 1946.

Immediate cause of death	Duration
Circulatory failure	
Due to Pulmonary edema	
Due to Rheumatic Heart Disease, mitral Stenosis & insufficiency & aortic insufficiency	
Other Conditions Subacute bacterial endocarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burton Rader M. D.
Address Sinai Hosp. Date signed 1-12-46

VS 150

X

G36369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G36369 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 8th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3235 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael G. Butcher

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5830

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19-1882

8. AGE: Years	Months	Days	If less than one day
63	2	24	hr. min.

9. Birthplace New Haven Conn.
(Town, county, and state)

10. Usual Occupation Howard Cleaning Co.

11. Industry or business

FATHER 12. Name Jacob Butcher
13. Birthplace France

MOTHER 14. Maiden Name Freida
15. Birthplace New Haven, Conn.

16 (a) Informant Mrs. Anna M. Butcher
(b) Address 3235 Belair Road

17 (a) Burial (b) Date thereof 1-15-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director Lloyd J. Luck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1946, at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull; Fracture of Left Leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4-1
(a) Date of injury December 30 1945 M.
(b) Where did injury occur? Pratt + Light Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury pedestrian struck by auto

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 1-13-46

VS 151

G36370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G36370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baynes Ave & Rutland St
(c) Hospital or institution: W. Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N (b) County
(c) City or town 1813 E. Pratt St. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Levine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, Married, Widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wolfe
13. Birthplace Lithuania

MOTHER
14. Maiden Name Rachael
15. Birthplace Lithuania

16 (a) Informant David Levine
(b) Address 1813 E Pratt st

17 (a) (Burial, cremation, or removal) (b) Date thereof Jan 14 1946 (month) (day) (year)
(c) Cemetery or crematory Jewish Point
Location Gwynn Oak Ave

18 (a) Funeral director Gans Levin Bros.
(b) Address 1469 E. Pratt. st

19 (a) [illegible] by registrar) Attending for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1946 at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1946 to 1-13 1946 and that I last saw her alive on 1-13 1946

Immediate cause of death Cerebral Hemorrhage
Brain Neoplasm? or Cerebro-Vascular Accident
Due to Uremia?
Due to
Other Conditions Diabetes Mellitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Baldwin M.D.
Address West Baltimore General Hosp. Date signed 1/13/46

correct age is especially important. Physicians: please write the ... of death clearly and legibly.

VS 150

57D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36371 / 170c

Registered No. G36371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Annapolis Rd. Po. 332
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Keller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daniel E. Keller

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 21-1885

8. AGE: Years 60 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Charles Muhlmeister
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Wandgardner
15. Birthplace Germany

16 (a) Informant Daniel E. Keller
(b) Address Defense Highway A.A. Co

17 (a) burial (b) Date thereof 1/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Marys Cem
Location Annapolis Md

18 (a) Funeral director E. W. Lamoreau
(b) Address 1063 W Baltimore St

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 14 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1946 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Pulmonary edema
Paralytic ileus
Due to Fr. fractured pelvis
Contusion of brain
Other Conditions
Fractured nose.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1 at 1-5-46 53.00 M.
(b) Where did injury occur Caton Ave. & West Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger of Auto

23. Signature Benedict Skotarelis M.D.
Medical Examiner.

Date signed Jan 14, 1946.

X

The causes of death clearly and legibly.

G36372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

G36372 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 N. Patterson Park Avenue (If rural, give locality)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bollinger

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26-1887

8. AGE: Years 58 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Plumbers Helper

11. Industry or business

FATHER 12. Name Joseph Bollinger

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Mary E. Ruth

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Margaret Bollinger

(b) Address 243 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director John A. Miller

(b) Address 2334 Jefferson St.

19 (a) Jan 14 1946 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1946 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Fontaine M.D. Medical Examiner.

Date signed Jan 12 1946

Dr. A. N. Brachlein
1328 St. Paul St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Evergreen Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Evergreen Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Christopher Charles Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11-1890

8. AGE: Years	Months	Days	If less than one day
55	9	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Superintendent
11. Industry or business Moreland Mem'l Pk. Cem.

FATHER
12. Name John J. Murphy
13. Birthplace N.Y.

MOTHER
14. Maiden Name Margaret Hanratty
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Murphy
(b) Address 2912 Evergreen Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date received by registrar) (b) Registrar

JAN 14 1946
VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to January 11 1946, and that I last saw he alive on January 11 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Coronary Artery Disease	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred N. Brachlein M. D.
Address 1328 St. Paul St. Date signed Jan 14/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registration No. G36374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Whitehead

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1930

8. AGE: Years 15 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Pagement N. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Theodore Whitehead
13. Birthplace Georgia

MOTHER
14. Maiden Name Bell Blakely
15. Birthplace Pagement N.C.

16 (a) Informant Mamie Bundy
(b) Address 210 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2229 W. Lafayette Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1946 at 2 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Exsanguination

Due to Stab wound of Neck

Other Conditions

(Include pregnancy within 2 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1:30 A.M. 1-10-46
(b) Where did injury occur? Rear of 210 N. Carey St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed

23. Signature Benedict Skotardis M.D. Medical Examiner.
Date signed Jan 10, 1946.

G36375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

G36375 Registered No.

Type or print plainly with pen. Fill in the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 235 N. Gilmor (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Rayland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1892

8. AGE: Years 53 | Months | Days 17 | If less than one day hr. min.

9. Birthplace Virginia - Va. (Town, county, and state)

10. Usual Occupation Home - Wife

11. Industry or business

FATHER 12. Name Buck Tuck
13. Birthplace Va

MOTHER 14. Maiden Name Jane Wilkins
15. Birthplace Va.

16 (a) Informant Lloyd Rayland
(b) Address 1317 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Wm. Peter L. Williams
(b) Address 220 N. Schroeder St.

19 (a) Date rec'd by Local Reg. (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1946, at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Rupture of Arteriosclerotic Aneurysm of Abdominal aorta
Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutarelic M.D. (Medical Examiner.)
Date signed 1-10-46

Huntington Ave

G36376

AB-94364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36376

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mos- 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15- 1870

8. AGE: Years 75 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Holloway or Toliferrow(D
13. Birthplace ?

MOTHER
14. Maiden Name Katherine Holmes (D
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals(Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15- 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn - Bon
Location

18 (a) Funeral director Dan Keith R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JAN 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11- 1946 at 4.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25- 1945 to 1-11- 1946 and that I last saw h er alive on 1-11- 1946.

Immediate cause of death
Uremia — Duration 7
Due to Pyelonephritis — 7
Due to — ,
Other Conditions ASHD
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pyelonephritis ASHD Uremia fatal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Davis M. D.
Address B.C.H. Date signed 1-12-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... information should be carefully supplied. The

133a

G36377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83a

G36377

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1860

8. AGE: Years 85 | Months 3 4 | Days 6 1 4 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Knight
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Helen Heintz
15. Birthplace Baltimore Md

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b)
Date rec'd by registrar JAN 14 1946 Registrar Burlington Williams, M.D.

VS 150.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 13 - 1946, at 12-50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 13 1946, and that I last saw her alive on Jan 10 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days

Due to: Cerebral Arteriosclerosis — 10 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E North Ave Date signed 1/13/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36378 BALTIMORE CITY HEALTH DEPARTMENT G36378

CERTIFICATE OF DEATH ✓ 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2134 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Rau

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Theodore H. Rau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1864

8. AGE: Years	Months	Days	If less than one day
81		15	hr. min.

9. Birthplace Howard County, Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John T. Jones
13. Birthplace Prince George Co. Md.

MOTHER
14. Maiden Name Eliza H. Jones
15. Birthplace Prince George Co. Md.

16 (a) Informant Mrs. Charles Jones
(b) Address 16 N. Pulaski St.

17 (a) Burial (b) Date thereof 1/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 2 S. W. Lombard

19 (a) JAN 14 1946 (b) Huntingtown Hollaway, Md.
Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10th 1946; at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945 to Jan 10 1945, and that I last saw h.e.r. alive on Jan 9, 1945.

Immediate cause of death	Duration
Chr. Cardio-Renal Vascular Disease	
Due to	
Due to	
Other Conditions Senility.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon MD
M. D.
Address 820 Medical & Dental Bldg. Date signed 1/14/46

X

G36379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G36379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 Annabel Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Annabel Ave
(If rural give location)
(e) Citizen of foreign country? Ud (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Michael Jezierski JEZIERSKI

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-12-2937

4. Sex male | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Wanda Killian

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) F. 18. 93.

8. AGE: Years 52 | Months 10 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, (town, county, and state)

10. Usual Occupation Babcalman.

11. Industry or business —

FATHER
12. Name Michael Jezierski
13. Birthplace Poland.

MOTHER
14. Maiden Name Clara Kochanski
15. Birthplace Poland,

16 (a) Informant Wanda L. Jezierski
(b) Address 629 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location City

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) ____ (b) ____ Registrar

JAN 14 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1. 12 1946, at 853 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1945 to Jan. 12 1946 and that I last saw h[illegible] alive on 1.12 1946

Immediate cause of death: Cardiac failure — Duration 2 Weeks

Due to Arteriosclerotic Heart disease. — 2 yrs

Due to —

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. G. Summers M. D.

Address 1045 Patapsco Ave Date signed 1-12-46

correct age is especially important. Physicians: please write the

G36380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G36380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 N. Fulton Ave.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	Col.	Married

6 (b) Name of husband or wife Isaiah Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1901

8. AGE: Years	Months	Days	If less than one day
44	10	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Briscoe
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriet Chase
15. Birthplace Maryland

16 (a) Informant Sarah Jones
(b) Address 1417 N. Fulton Ave.

17 (a) Burial (b) Date thereof 1/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 303 Preasbman St

JAN 14 1946
(Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22, 1945, to Jan. 11, 1946, and that I last saw h.e alive on Jan 11, 1946

Immediate cause of death	Duration
Uremia	2 days
Due to Cardio-Vasc-Renal Disease	8 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.
Address 2445 D. Hill Ave. Date signed 1-14-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125B

G36381 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs care

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre de Grace (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 Otsego St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME GARFIELD C. TAWNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lula J. Tawney

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 26-1880

8. AGE: Years 65 | Months 6 | Days 14 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name John Tawney
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Rawsworth
15. Birthplace Md

16 (a) Informant Chester W. Tawney
(b) Address Calvert Chapel Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-46 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace Md

19 (a) JAN 14 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1946 to 1/12 1946, and that I last saw him alive on 1/12 1946

Immediate cause of death Cerebral Vascular Collapse — Duration

Due to Acidosis

Due to Uremia

Other Conditions Obstructive Jaundice (Include pregnancy within 3 months of death)

Date of operation 1/12/46

Major findings of operation: Mass originating ascending colon, of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Straker Jr. M.D.
Address Mercy Hosp. Date signed 1/12/46

VS 150 Pennington & Son

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Print or type the causes of death clearly and legibly. Physician: please write the exact cause of death.

G36382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No. G36382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and name town)
(d) Street No. Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hugh Kyle Arnold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mattie M. Arnold

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1893

8. AGE: Years 52 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation Tape business

11. Industry or business

FATHER
12. Name John Arnold
13. Birthplace Tennessee

MOTHER
14. Maiden Name Elizabeth Mathes
15. Birthplace Tennessee

16 (a) Informant H. L. Gaither Jr.
(b) Address 9 Engan Ave. Catonsville Md.

17 (a) Burial (b) Date thereof Jan 17, 1946 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) Date received by local registrar (month) (day) (year) (b) Huntington Williams M.D. Registrar

JAN 14 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1946, at 4:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D. Medical Examiner.
Date signed 1-14-46

G36383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 84a

G36383 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17Hrs. 35Min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Silver Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Singhass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-46

8. AGE: Years | Months | Days | If less than one day 17 hr. 35 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Stanley Jacob Singhass
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Darlee Wione McGreevy
15. Birthplace Baltimore Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves. Balto. Md.

19 (d) JAN 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14-46 19 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9:00 A.M. 1/13 1946 to 3:15 A.M. 1/14 1946 and that I last saw him alive on 1/14 1946.

Immediate cause of death: Congenital Atelectasis — Duration: 17 hrs 35 min.

Due to: Hemaglacia Idiocy

Due to:

Other Conditions Malformations of mouth & genital organs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Stickel Jr. M. D.
Address Bon Secours Hosp. Date signed 1/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

G36384 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 S. Eden St.
(c) Hospital or institution: /
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Martin

3 (b) If veteran, name war: 1st World
3 (c) Social Security Account No. 216-16-0044

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: married

6 (b) Name of husband or wife: Anna Martin
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 1887

8. AGE: Years: 58 | Months: 2 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Philadelphia, Pa (Town, county, and state)

10. Usual Occupation:
11. Industry or business: Laborer

FATHER
12. Name: Thomas Martin
13. Birthplace: Philadelphia

MOTHER
14. Maiden Name: Mary Gorman
15. Birthplace: Belfast, Ireland

16 (a) Informant: Anna Martin
(b) Address: 222 S. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 14 1946 (month) (day) (year)
(c) Cemetery or crematory: St. Mathias
Location: Edmondson Ave

18 (a) Funeral director: Wendell Shipley
(b) Address: 3125 Highland Ave

19 (a) JAN 14 1946 (Date received by local registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 11 1946 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to JAN 11 1946, and that I last saw h[illegible] alive on JAN. 9 1946.

Immediate cause of death	Duration
Decompensating cardio-renal Vascular disease	4 mos +
Due to: Arteriosclerosis	5 yrs +
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: David Schneider
Address: 1101 N. Charles Ave Date signed: M. D. 1-13-46

VS 150

X

G36385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 S. Dallas Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARYANNA JESKIEWICZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 12, 1860

8. AGE: Years 85 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name ---- Gawronski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Walter Jeskiewicz
(b) Address 515 S. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski Sons
(b) Address 1808 Eastern Avenue

19 (a) Date received by Registrar JAN 14 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1946, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 19 Jan 11 1946, and that I last saw h[illegible] alive on Jan 11 19 46

Immediate cause of death: Coronary Thrombosis — Duration 1/10/46

Due to: Hypertension Cardio Vascular Disease — 1940

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature William J Roarer M. D.

Address 801 N. Redwood St. Date signed 1/12/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36386 G36386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Bonnerry Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Foote

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-9487

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charles E Foote

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Sarah James

15. Birthplace Baltimore Md

16 (a) Informant Carrie Foote

(b) Address 908 Russell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Md

18 (a) Funeral director Isaac L Kirwan Son

(b) Address 1058 W Monroe St

19 (a) (Date received by registrar) (b) JAN 14 1946 Registrar for Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1946 at 12:40 P

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skiturski M.D. Medical Examiner.

Date signed 1-11-46

G36387 BALTIMORE CITY HEALTH DEPARTMENT G36387

CERTIFICATE OF DEATH √94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Fayette Sts
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 Cleveland (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Sigwart (Sigwart)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 04 1883

8. AGE: Years 62 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Levy Bro.

FATHER 12. Name Theodore Sigwart

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Wiseman

15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Christine Wallnofer

(b) Address 1231 Cleveland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Fred Road

18 (a) Funeral director John J. Brown & Son

(b) Address 904-03 Gallows St

19 (a) (Date rec'd by local reg.) JAN 14 1946 (b) Huntington Will Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1946 at 3:35 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Gladden M.D. (Medical Examiner)

Date signed 1-11-46

Rahe

BALTIMORE CITY HEALTH DEPARTMENT

G36388 CERTIFICATE OF DEATH 170c Registered No. G36388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts.
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gordon Rahe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age 4 years

7. Birth date of deceased (mo., day, yr.) May 4th 1936

8. AGE: Years 9 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER 12. Name Geo Rahe

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Katie Rahe

15. Birthplace Baltimore Md

16 (a) Informant Mrs Katie Rahe

(b) Address 1114 W Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/46 (month) (day) (year)

(c) Cemetery or crematory Westport Cem

Location Longwood & Edmondson Ave

18 (a) Funeral director John J Conway & Son

(b) Address 961-63 Hollins Street

19 (a) (Date received by registrar) (b) 1946 Jan 15 0 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury January 13 1946 1:30 P.M.

(b) Where did injury occur? Howard & Carroll Sts

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by auto

23. Signature Robert L. Fenton M.D. Medical Examiner.

Date signed 1-13-46

X

G36389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G36389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address NORTH BROADWAY
(c) Hospital or institution: THE CHURCH HOME & HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 4 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE - 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5017 FALLS ROAD TERRACE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME OLIVETTA PARKER DENNY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JOSEPH J. DENNY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 14, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	28	hr. min.

9. Birthplace KENTUCKY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business AT HOME

FATHER
12. Name EDWIN PARKER
13. Birthplace KENTUCKY

MOTHER
14. Maiden Name ANNETTE BOTCHER
15. Birthplace ENGLAND

16 (a) Informant PATIENT (OLIVETTA P. DENNY)
(b) Address 5017 FALLS ROAD TERRACE

17 (a) Cremation (b) Date thereof 1/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Penna Aves.

19 (a) JAN 14 1946 (b) Huntington Williams M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 12 1946, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1946, to 1-12 1946, and that I last saw HER alive on 1-12 1946.

Immediate cause of death	Duration
PULMONARY EDEMA, BILATERAL	
Due to	
Due to	
Other Conditions ATELECTASIS, RT. LOWER LOBE; ATHEROSCLEROSIS; NEPHROSCLEROSIS. (Include pregnancy within 3 months of death)	

Date of operation 1-7-46
Major findings of operation: POST OPERATIVE VENTRAL HERNIA
of autopsy PULMONARY EDEMA, ATELECTASIS, ETC.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James B. Little Jr. M. D.
Address Church Home & Hospital Date signed 1-12-46

Please write plainly, with pen or typewriter. Every item must be answered. Use information already on record or obtainable. Physicians: please write the correct age in years, and the causes of death clearly and legibly. This is especially important.

VS-150

G36390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G36390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 Francis
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 93yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Francis (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen S. Marriott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Milton M. Marriott

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 8 - 1852

8. AGE: Years 93 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business At Home

FATHER 12. Name Thomas D. Nicholson

FATHER 13. Birthplace Balto. Md

MOTHER 14. Maiden Name Eleanor Jean

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Mrs. Addie Marriott

(b) Address 2528 Francis St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director Wm. J. Tinkenthorn

(b) Address North Ave

19 (a) JAN 14 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1946, at 1A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to Jan. 13 1946, and that I last saw her alive on Jan. 13 1946.

Immediate cause of death	Duration
Cerebral Hemorrage.	1/2/46
Due to Chr. Myocarditis	1940
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brune M. D.

Address 1663 N Caroline Date signed 1/13/46

Entry must be made in ink. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G36394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bradford Apts 33rd & St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. BradfordApts. 33rd & St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME T. Elizabeth Lucius

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1887

8. AGE: Years	Months	Days	If less than one day
58	3	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Federal Reserve Bank

FATHER
12. Name Henry Lucius
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amelia L. Brummer
15. Birthplace Baltimore, Md.

16 (a) Informant H. W. Lucius
(b) Address 207 Paddington Road

17 (a) Burial (b) Date thereof 1/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH January 12, 1946 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1930 to Jan 12 1946 and that I last saw him alive on Jan 12 1946

Immediate cause of death: Coronary Thrombosis — Duration: 3 min.
Due to: arteriosclerosis — 1 year
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Lucius M. D.
Address 2706 St Paul St Date signed 1/14/46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G36392 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Asquith St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Asquith
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward M. Lockett

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary L. BETZ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1873

8. AGE: Years 72 | Months ✓ | Days 26 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Lockett
13. Birthplace North Carolina

MOTHER 14. Maiden Name Sarah Lowtier
15. Birthplace North Carolina

16 (a) Informant Marie Lockett
(b) Address 2300 Asquith St

17 (a) BURIAL (b) Date thereof JAN 15 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4200 BELAIR ROAD

18 (a) Funeral director MARTIN W. E. DIPPEL'S SONS
(b) Address LOMBARD & ANN STS

19 (a) Date rec'd by local registrar JAN 14 1946 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939 to Jan 12 1946 and that I last saw him alive on Jan 12 1946.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J. Gould M. D.
Address 14 N Gaston Ave Date signed 1-14-46

VS 150

G36393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36393 Registered No.

1. PLACE OF DEATH: 46 S. Fulton Ave
(a) Baltimore City, Maryland
(b) Street address 46 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 46 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Hammerbacher

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna M. Hammerbacher
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1862

8. AGE: Years 83 | Months 9 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Insurance Agent

11. Industry or business Insurance

FATHER 12. Name Daniel Hammerbacher
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Anna M. Hammerbacher
(b) Address 46 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Raymond Kaufman
(b) Address 1026 Leeds Ave.

19 (a) ... (Date rec'd by registrar) (Huntington Williams Signature)

JAN 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1946 at 5 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan. 12 1946, and that I last saw h— alive on Jan 12 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 7 days
Due to Senile Debility
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Thos. H Phillips M. D.
Address 1939 Edmonds Date signed 1-14-46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36394 7100 BALTIMORE CITY HEALTH DEPARTMENT G36394

CERTIFICATE OF DEATH V159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 McPhail Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Mc Phail Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby of Mrs. Bertha Beyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-46

8. AGE: Years	Months	Days	If less than one day
	6/12 mo.	Foetus	2 hr. min.

9. Birthplace 114 McPhail Street
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam Beyer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha Stroekman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Beyer
(b) Address 114 McPhail Street

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-15-46 (month) (day) (year)
(c) Cemetery or crematory Md. Cemetery
Location Frederick Rd.

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address 600 Hollins St.

19 (a) JAN 14 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14-1946, at 11:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-14-46

VS 151

Write for Baltimore, Md.

G36395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G36395 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 27 - 9 Hielen
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town) + Arlington
(d) Street No. Morgan College (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-83

8. AGE: Years 62 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Smithfield, Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Travis
13. Birthplace Va

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Edward P. Hurt
(b) Address Morgan College

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory Flushing Cemetery
Location Flushing N.Y.

18 (a) Funeral director Hugh L Nelson
(b) Address 303 Prestman St

19 JAN 14 1946 (Date received by registrar) (b) Wilmington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1946, at 11:29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1- 1945, to 1-13- 1945 and that I last saw her alive on 1-13- 1945

Immediate cause of death	Duration
Carcinoma of right breast with metastasis	
Due to	
Due to	
Other Conditions Arteriosclerosis with hypertension (Include pregnancy within 3 months of death)	

Date of operation June, 1945
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.P. Campbell M. D.
Address 718 Dolphin St. Date signed 1-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G36396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G36396 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3044 Arunah Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Shipley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23,1860

8. AGE: Years	Months	Days	If less than one day
85	11	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Johnzee Sellman Shipley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louisa Ann Gawthorp
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Gertrude Lilly
(b) Address Roslyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 4510 Liberty Heights Ave.

19 JAN 14 1946 (b) Date rec'd by local registrar — Signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946, at 9.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 2, 1931 to Jan. 11, 1946, and that I last saw h er alive on Jan. 10, 1946

Immediate cause of death — Duration
Coma — 8 days
Due to Chronic myo-endocarditis — 8 years
Due to Coronary Thrombosis — 3 years
Other Conditions Hypertension & arteriosclerosis — 16 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice B. Shamer M. D.
Address 3300 W. North Ave. Date signed 1/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Park Avenue
(c) Hospital or institution: Friends Home 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 years
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelia Stabler Reese

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr-1-1860

8. AGE: Years	Months	Days	If less than one day
85	9	12	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Gerard H. Reese
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah J. Janney
15. Birthplace Virginia

16 (a) Informant Miss Mabel Reese
(b) Address 1405 Mt. Royal Terrace

17 (a) Burial (b) Date thereof Jan 15 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends Burying Ground
Location Baltimore Md.

18 (a) Funeral director Stewart & Women's Co.
(b) Address 108-20 North Ave, City.

JAN 15 1946
(Date rec'd by registrar)
(b) Huntington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1946, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 1944, to Jan 13 1946, and that I last saw h[illegible] alive on Jan 13 1946.

Immediate cause of death	Duration
Myocardial insufficiency	2 days.
Due to Cardiac Decompensation	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Hammond Hood M. D.
Address 2200 Garrison Blvd Date signed 1/14/46

G36398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G36398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 St. Paul st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie L. Zachary

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George E. Zachary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25th 1885

8. AGE: Years	Months	Days	If less than one day
60	6	18	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Delbert D. Tapscott
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Lysell
15. Birthplace Va.

16 (a) Informant Rev. Geo. E Zachary
(b) Address 1001 St. Paul st

17 (a) Removal (b) Date thereof 11/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fredericksburg
Location Va.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul st.

19 (a) NOV 15 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13th 1946; at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1942 to Jan. 13 1946 and that I last saw h[illegible] alive on Jan. 13 1946

Immediate cause of death	Duration
Carcinoma of left kidney	2 1/2 years
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation Dec. 29, 1944
Major findings of operations Carcinoma of left kidney
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John Talbot Howard M. D.
Address 12 E. Eager St. Date signed Jan. 14, 46

VS 130

Please write plainly in ink; WRITE UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G36399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. CALVERT St.
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. REDWOOD St.
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN DANIELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOWER

6 (b) Name of husband or wife DECEASED
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-1888

8. AGE: Years 57 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation WINDOW CLEANER

11. Industry or business

FATHER
12. Name MARTIN DANIELS
13. Birthplace NORTH CAROLINA

MOTHER
14. Maiden Name ANNIE BELL
15. Birthplace NORTH CAROLINA

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 15 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1945 at 5.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1945 to 12-29 1945, and that I last saw h[illegible] alive on 12-29 1945

	Duration
Immediate cause of death CARDIO-RESP. FAILURE	1 DAY
Due to PORTAL CIRRHOSIS with ASCITES	15 years intermittent
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E. Rudd M. D.
Address Mercy Hospital Date signed 12-29-45

VS 150

FURNISH WHITE FLAGS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636400

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 636400

CERTIFICATE OF DEATH 124B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town near Camp Meade
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Newton

3 (b) If veteran, name war: Unknown
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years: 46 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual Occupation: Unknown
11. Industry or business:

FATHER
12. Name:
13. Birthplace: Not Obtained

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Hubbard Davenport
(b) Address: 222 Stimmer Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Johns Hopkins Medical School
Location:

18 (a) Funeral director: Commissioner of Health
(b) Address:

19 (a) JAN 15 1946 (Date rec'd by registrar) (b) by Hunter Williams, M.D. Registrar

JAN 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1945, at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 PM 12-24 1945 to 8:35 AM 12-25 1945 and that I last saw h[illegible] alive on Dec 25 1945

Immediate cause of death	Duration
Cardio-Respiratory Failure	15 Min
Due to Portal Thrombosis	Unknown
and Generalized Anasarca	Unknown
Due to	
Other Conditions Stasis Dermatitis	
Late Preg.	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Joseph E. Reall M. D.
Address: Mercy Hospital Date signed 1-2-46

VS 150

3220 X

G36401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 190

Registered No. G36401

Type or print clearly in black ink. Do not use abbreviations. If unknown, write unknown. Do not leave blanks. If none, write none. Underlying causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Earth near 1910 Fremont ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eddie Owens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65?		1	hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 14 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 15 1946 (b) Washington-Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1946, at 2 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Exposure to cold

Due to

Other Conditions Wanted pulmonary Emphysema
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury found Jan 2 1946 21/2 P M.
(b) Where did injury occur? Near 1910 Fremont St
(c) Did injury occur at home, on farm, industrial place, in public place? Old shack While at work? No
(d) Means of injury Cold & exposure

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Jan 4th 1946

VS 151

F3319 X

G36402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 36402

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. General Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Eutaw Place
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bernard King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) Burial (b) Date thereof 1/17/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Matthews Cem. E. Baltimore Co., Md.
Johns Hopkins Medical School JAN 14 1946
Location 1701 N. Patterson Park Ave.
18 (a) Funeral director Commissioner of Health

(b) Address.....

19. JAN 15 1946 [signature illegible] Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury.....at.....M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....

(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Dec. 29 1945

10218

Correct and legible. Extremely important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

G36403 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 S. POTOMAC ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 S. POTOMAC ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM S. ADAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	DIVORCED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 4 1875

8. AGE: Years	Months	Days	If less than one day
70	6	9	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation BLACKSMITH
11. Industry or business

FATHER
12. Name JAMES B. ADAMS
13. Birthplace VA.

MOTHER
14. Maiden Name FRANCIS JARVIS
15. Birthplace VA.

16 (a) Informant WM. N. ADAMS (SON)
(b) Address 915 S. POTOMAC ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 16/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

VS JAN 15 1948 Inserting for Williamsport, Md.

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH JAN. 13 1946 at 10/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 29 1945 to Jan. 13 1946 and that I last saw him alive on Jan. 13 1946

Immediate cause of death Coronary Thrombosis — Duration Unknown
Due to Pulmonary
Due to
Other Conditions Acute Pulmonary Emphysema — a few minutes
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. A. Rosenblatt M. D.
Address 3018 O'Donnell St. Date signed 1-14-46

G36404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this form only. Do not use abbreviations. Items of information are required from every certificate. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Broadway (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jeanette Nichols

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband, ~~or wife~~ ~~Wm H Nichols~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10 1863

8. AGE: Years	Months	Days	If less than one day
82	11	4	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name John Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Eitzgerald
15. Birthplace New York

16 (a) Informant Home Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Butzbach & Son
(b) Address 2324 N Charles St

19 (a) (Person acting as Registrar) (b) Registrar

JAN 15 1946 Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1946, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1945 to 1-14 1946, and that I last saw h~~e~~r alive on 1-14 1946

Immediate cause of death Coronary occlusion — Duration

Due to Coronary sclerosis

Due to

Other Conditions Hypertension arteriosclerosis CVD
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home Date signed 1-14-46

G36405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36405 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 93 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE GRAU JR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWER

6 (b) Name of husband or wife Mary Miller Grau
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 20,1851

8. AGE: Years	Months	Days	If less than one day
94		24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Cloth Cutter
11. Industry or business Retired

FATHER
12. Name George Grau Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Roth
15. Birthplace Germany

16 (a) Informant Mrs. Lydia Brenner
(b) Address 3117 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15. 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 15 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13. 1946 at 2.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1946 to 1-13 1946. and that I last saw h.. alive on 1-12 1946.

Immediate cause of death Chronic myocarditis — Duration

Due to Senility

Due to

Other Conditions Broncho pneumonia 3 da.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Owen Moore M. D.
Address 3105 Belair Rd Date signed 1-14-46

X

G36406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1642 Registered No.

G36406

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 East Eager St. (If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARGARET E. CONSIDINE

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19, 1921

8. AGE: Years	Months	Days	If less than one day
24	9	24	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business Unemployed

FATHER
12. Name James R. Considine
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Fröhlich
15. Birthplace Baltimore, Md.

16 (a) Informant Evelyn Sullivan
(b) Address 8 E. Eager

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1312 Pont St.

19 (a)..... (b) Huntington, Indiana, U.S.A. (Date received by registrar) JAN 15 1946 Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18/46, 19....., at 5:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy / Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to Hanging

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/18/46 at 4 P.M. M.
(b) Where did injury occur? 8 East Eager
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Self Inflicted Hanging

23. Signature John P. Davis M.D. (Medical Examiner)
Date signed 1/14/46

G36407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G36407 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Douglass Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Silva

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Richard Noland
13. Birthplace Md

MOTHER
14. Maiden Name Mary Carter
15. Birthplace Md

16 (a) Informant Miss Silvina Furtado
(b) Address 1120 E Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Leroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) JAN 15 1946 (Date received by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Furtado M.D. Medical Examiner.
Date signed 1-13-46

Cover age is especially important. Physicians: please write the causes clearly and legibly.

G36408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36408 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Kingston Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Kingston Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Stanley Little

3 (b) If veteran, name war: *****

3 (c) Social Security Account No. 212 03 4793

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie C. Little
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 11, 1884

8. AGE: Years 61 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Funeral Director

11. Industry or business

FATHER
12. Name George W. Little
13. Birthplace York Penn.

MOTHER
14. Maiden Name Ella R. Peregoy
15. Birthplace Baltimore, Md.

16 (a) Informant George W. Little
(b) Address 2700 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16, 46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md.

18 (a) Funeral director George W Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by Registrar) JAN 15 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1946, at 6:55 p.m. M

21. I certify that death occurred on the date above-stated; that I attended deceased from Nov. 15 1945, to Jan 12 1946, and that I last saw him alive on Jan. 11 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1/12/46
Due to Coronary Sclerosis	1939
Due to Chr. Myocarditis	1939
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Brown
Address 16630 North Ave. Date signed 1/14/46 D.

G36409

CWK-60140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

✓ G36409 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 2- 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Payne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22-1868

8. AGE: Years	Months	Days	If less than one day
77	0	19 20	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Payne
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof I-15-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) JAN 15 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH January 11 1946, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1940 to Jan. 11 1946 and that I last saw h❜F alive on Jan. 11 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension, cardio-vascular disease	
Due to	
Other Conditions Pneumonia, Lobar.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathon Rowland M. D.
Address B.C.H. Date signed 1/14/46

VS 150

8 930

G36410 G36410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5608 Greenhill Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wells, Harry Clarence

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-4800

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Thelma ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1900

8. AGE: Years	Months	Days	If less than one day
45	11	1	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Messman
11. Industry or business seafarer

FATHER
12. Name Harry C. Wells
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Lula ?
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 1/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director John A. Moran
(b) Address 401 Dreamont Ave

19 (a) JAN 15 1946 Huntington, Md.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1946, at 9:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1945, to Jan. 12 1946, and that I last saw him alive on Jan. 12 1946.

Immediate cause of death Hemorrhage, cerebral, pons — Duration 3½ hrs

Due to

Due to

Other Conditions Arteriosclerosis, cerebral and coronary
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

UNKNOWN

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon, M.D.
Address Clinical Director Date signed 1/14/46
US Marine Hospital, Balto, Md.

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-98322 636411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 636411

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Mary Eastwood

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Howard Eastwood
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 22- 1889

8. AGE: Years	Months	Days	If less than one day
56	8	21	hr. min.

9. Birthplace [illegible]. Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Hagner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Bomsacek
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan. 17, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location - Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Date received by local registrar (b) Registrar's No.

JAN 18 1946

Huntington Hillegeist

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13- 1946, at 3.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5- 1946 to 1-13- 1946 and that I last saw her alive on 1-13- 1946

Immediate cause of death	Duration
[illegible] and result of generalized Carcinomatosis	4 yr.
Due to Ca of Stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: no op multiple abdominal adhesions + fistulae
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address B C R Date signed 1-14-46

X

G36412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 G36412

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry B. Bogash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Claira

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Phila. Pa (Town, county, and state)

10. Usual Occupation meat Market

11. Industry or business

FATHER
12. Name Lev. Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Clair Bogash
(b) Address 3602 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-46 (month) (day) (year)
(c) Cemetery or crematory Nether Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1629 E. Balto St

19 (a) (Date stamp by registrar) (b) Registrar

JAN 13 1946
VS 15+

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1946, at 7:15 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sabinske M.D. Medical Examiner.
Date signed 1/17/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G36413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5036 Queensbury Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5036 Queensbury Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Erkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Mendel
13. Birthplace Russia

MOTHER
14. Maiden Name Hanyah
15. Birthplace Russia

16 (a) Informant Al Braunstein
(b) Address 2525 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-46 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Philg Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1429 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

Jan 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14-1946 at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1945 to Jan-14-1946, and that I last saw her alive on Jan-14-1946.

Immediate cause of death Uremia — Duration: conge renal

Due to chronic nephritis

Due to Polycystic Kidneys

Other Conditions hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Herman Seidel M.D.
Address 2404 Eastern Ave Date signed 1/14/46

X

G36414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G36414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2248 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Nathan Mander
(b) Address 2248 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14-1946, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1945 to Jan. 14 1946 and that I last saw h[illegible] alive on Jan. 14 1946.

Immediate cause of death
(a) Carcinoma of Left Kidney
Due to (b) Generalized Arteriosclerosis.
Due to (c)
Other conditions Acute Arteriosclerosis —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

V2715.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify kind of place) While at work?
(e) Means of injury

23. Signature Harry Primakoff M.D.
Address 1 West Mt. Royal Ave. Date signed 1/14/46
Attn: Dr. Primakoff

VS 150

G36415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G36415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Sugar

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Chaim
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hart Perach
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Workman Circle

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) [redacted] Huntington Williams, M.D. (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1946, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1944, to 1-14 1946, and that I last saw her alive on 1-14 1946.

Immediate cause of death: Cerebral Hemorrhage
Due to: Arterio Sclerosis; Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Edmund Levin, M.D.
Address Levindale Date signed 1/14/46

G36416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36416 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor + Shakeland
(c) Hospital or institution: West Balto Gen. Hosp. V O
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Ramsay Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Koehler

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: F.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Herman Koehler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 4 1873

8. AGE: Years 72 | Months 8 | Days — | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name ? Hoffman
13. Birthplace Germany
MOTHER: 14. Maiden Name Mary Brooks
15. Birthplace Unknown

16 (a) Informant Raymond Wm. Koehler
(b) Address 2023 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George L. Pilchard
(b) Address 2101 Frederick Avenue
JAN 15 1946 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 January 1946, at 9.05 A.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 12 Jan 1946 to 14 Jan 1946
and that I last saw her alive on 14 Jan 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Accident - Apo. undetermined	
Due to Arteriosclerotic C.V. Dis.	
Other Conditions Nodular Thyroid	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Estes A. Hall M.D.
Address West Balto Gen Hosp Date signed M/D. 1/14/46

VS 150

G36417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36417
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1149 Ridgely Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 Ridgely Street (If rural, give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Nobitha A. Reed

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: A. Walter Reed.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 6, 1887

8. AGE: Years 58 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Henry East
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Emily Jenkins
15. Birthplace: Maryland

16 (a) Informant: Mrs. Mildred Seigell
(b) Address: 1149 Ridgely Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-46 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: Geo. L. Schwab
(b) Address: 2101 Frederick Ave.

19 (a) JAN 15 1946 (Date rec'd by Registrar) (b) Huntington Williams Md.

VS 150

MEDICAL CERTIFICATION:

20. DATE OF DEATH January 14 1946, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 14 1946, and that I last saw h[illegible] alive on Jan 14 1946.

Immediate cause of death	Duration
Acute Pulmonary Oedema	1 day
Due to Hypertension	12 yrs
Due to Myocarditis.	1 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry Hates, M. D.
Address 517 Scott St Date signed 1/14/46

G36418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/138

G36418 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 Tolcroft St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Tolcroft St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) **FULL NAME** Walter E. Malecki

3 (b) If veteran, name war No

3 (c) Social Security Account No. 212-12-4539

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cecilia Brukiewa

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 16-1880

8. AGE: Years 65 | Months 7 | Days 29 | If less than one day ___ hr. ___ min.

9. Birthplace Germany
(town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Farming Industry

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Cecilia Malecki
(b) Address 322 Tolcroft St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director Stephen J. Tuskowski Inc
(b) Address 1000 So. Kenwood Ave.

19 (a) JAN 15 1946 (Date received by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Jan. 1946 at 1:30 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 14 1946, and that I last saw h. alive on Jan 12 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration 1-2-46

Due to:

Due to:

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed Schimanek M. D.

Address 842 S. Ext Ave Date signed 1-15-46

G36419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G36419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3625 Coolidge Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 Coolidge ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Bokman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife late Chas. A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1865

8. AGE: Years 80 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. Boyd
(b) Address 3625 Coolidge ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave + Gay St.

18 (a) Funeral director Harry H. Kittle
(b) Address 4101 Edmondson Ave.
(Place of death or removal) Washington Williams M.D. Registrar

JAN 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14/46. 19 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10/46 19 to 1/14 1946, and that I last saw h alive on 1/14 1946.

Immediate cause of death: Arteriosclerotic cardiovascular disease — Duration 6 mos

Due to:

Due to:

Other Conditions: Cerebral thrombosis — 2 days

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Weller M.D.
Address 1130 Watkins Date signed 1/15/46

VS 150

see X

G36420
486331

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
54 a

Registered No. G36420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County.....
(c) City or town Rutherford (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 E. Charlotte St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Francis Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-29.

8. AGE: Years	Months	Days	If less than one day
16	2	5	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Robert R. Miller
13. Birthplace N.C.

MOTHER
14. Maiden Name Lila Carpenter
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan. 15' 46 (month) (day) (year)
(c) Cemetery or crematory.....
Location Marion N.C

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by local registrar) JAN 16 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1946 at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1946 to Jan. 13 1946 and that I last saw him alive on Jan. 13 1946.

Immediate cause of death Cardiac arrest
Due to Lung abscess
Due to Brain abscess
Due to post operative.
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation 1/8/46
Major findings of operation: Cerebellar abscess
of autopsy: Streptococcus.

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Paul Saunders M.D.
Address Johns Hopkins Hosp. Date signed 1/14/46

G36421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36421 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mutlin Square 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1700 Pierce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Fay McAllister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1946 - 1 - 1

8. AGE: Years | Months | Days 11/4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Neal McAllister
13. Birthplace Raeford, N.C.

MOTHER
14. Maiden Name Anna Purcell
15. Birthplace Raeford N.C.

16 (a) Informant Neal McAllister
(b) Address 1700 Pierce St.

17 (a) Burial (b) Date thereof Jan 15th 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Tatie R Williams
(b) Address 323 N Schroeder St

19 (a) JAN 15 1946 (b) Hunting for Williams, Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12, 1946 at 3 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-pneumonia
Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed 1-12-46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

636422 / 15B — Registered No. G36422

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 N. Carrollton Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: James Bell

3 (b) If veteran, name war: —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 1905

8. AGE: Years: 41 40 | Months | Days | If less than one day: hr. min.

9. Birthplace: md (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER — 12. Name: Unobtainable

13. Birthplace

MOTHER — 14. Maiden Name

15. Birthplace

16 (a) Informant: Elizabeth Stewart

(b) Address: 4338 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/16/46 (month) (day) (year)

(c) Cemetery or crematory: St Peters

Location: md

18 (a) Funeral director: Geo. D. Kelson

(b) Address: 1303 Preston St.

19 (a) JAN 15 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 — 1946, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cardiac hypertrophy; acute cardiac failure

Due to: Rheumatic endocarditis

Other Conditions: Complete collapse of entire rt. lung old tuberculosis (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature: Benedict Skitarelic M.D. (Medical Examiner)

Date signed 1-14-46

58B

G36423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G36423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4115 RIDGEWOOD AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4115 RIDGEWOOD AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARAH ELMIRA HARCUM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife SAMUEL B. HARCUM 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 18-1861

8. AGE: Years 84 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER 12. Name SOUTHAL SHELTON
13. Birthplace VIRGINIA

MOTHER 14. Maiden Name PAIGE W. FITZHUGH
15. Birthplace VIRGINIA

16 (a) Informant ELBERT AIKEN
(b) Address 4115 RIDGEWOOD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE MD.

18 (a) Funeral director Ellsworth Armacost
(b) Address 89 N Sibley, Hagerstown

JAN 15 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1946, at 3Q M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to 1-13 1946, and that I last saw him alive on 1-12 1946.

Immediate cause of death	Duration
Asphyxiation Pneumonia	
Due to Senility & Edema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Med Arts Date signed 1-15-46

VS 180

G36424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 135a

G36424 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: McSherry Hosp. Keli[illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) most of life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Southern Area Hts (13a)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Theiss

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Louis Heyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1875

8. AGE: Years 70 | Months 3 24 | Days ? 26 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name John Kluget
13. Birthplace Germany

MOTHER 14. Maiden Name Anna Leitz
15. Birthplace Baltimore

16 (a) Informant Mary Theiss
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-46 (month) (day) (year)

(c) Cemetery or crematory Cedar Bluff.
Location Annapolis Md

18 (a) Funeral director Roman W. Baughman
(b) Address New Burnside Md

19 (a) [illegible] (b) Huntington Hill Undertaker, Md.
(Address of undertaker)

MEDICAL CERTIFICATION

20. DATE OF DEATH Thursday 13 1946 at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Jan 13 1946 and that I last saw h[illegible] alive on Jan 13 1946

Immediate cause of death — Duration
Uremia — 24 hrs
Pulmonary Edema
Due to
Due to
Other Conditions Pulmonary Edema, Chronic Cystitis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Larry Lawrence Jr. M.D.
Address Medical Arts Bldg Date signed 1/13/46

Sanders 111c

VS 150

G36425

AB-77530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36425 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs- 3mos. 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto H Guerth

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Lena (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17- 1867

8. AGE: Years	Months	Days	If less than one day
78	-	26	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired Florist
11. Industry or business

FATHER
12. Name Henry Guerth
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Struth
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan 16, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. Mrs. John W. Tyrpel & Son
(b) Address 1946 W. Fayette St

19 JAN 15 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13- 1946 at 2.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21- 1942 to 1-13- 1946 and that I last saw h im alive on 1-13- 1946

Immediate cause of death Cardiac Failure — Duration

Due to arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hall Date signed 1-17-46

VS 150

G036426

GROSS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G036426

Registered No.

HB # 48496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Claggett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Gross

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-4241

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Mamma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years	Months	Days	If less than one day
58?			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? (d)
13. Birthplace Md.

MOTHER
14. Maiden Name ? (d)
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Lexington St.

19 (a) Filed Jan 15 1946 Lexington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1946, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12, 1946 to Jan. 13, 1946 and that I last saw him alive on Jan. 13, 1946

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.

Address E. Balt. Date signed 1/14/46

VS 150

107

G36427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 S. Wolfe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Bujewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow.

6 (b) Name of husband or wife Michael Bujewski 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Kurek
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Frank Bujewski
(b) Address 613 S. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 16 46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 40[illegible] S. Chester Street

19 (a) JAN 15 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to Jan. 12 1946; and that I last saw h[illegible] alive on Jan. 12 1946.

	Duration
Immediate cause of death Hemiplegia	2 yrs.
Due to Chronic Nephritis	about 4 yrs.
Due to Hypertension	about 4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Szczerbicki M. D.
Address 1802 Eastern Date signed 1-14-46

Washington Hill, Registrar

X SZCZERBICKI

G36428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36428 Registered No. 164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1752 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earle S. Fuchslueger

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-7648

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: (1) Married

6 (b) Name of husband or wife: Evelyn M. Fuchslueger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 1922

8. AGE: Years 23 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business merchant marine

FATHER 12. Name Conrad Fuchslueger.
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Kutzner
15. Birthplace Balto. Md

16 (a) Informant Mrs. Mary Mach
(b) Address 1762 Bank St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore City

18 (a) Funeral director John H. Weber
(b) Address 401 S. Chester Street

19 (a) JAN 15 1946 (Date rec'd by registrar) (b) Registrar

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1946, at 8 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Head

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 13, 1946 M.
(b) Where did injury occur 1752 Bank St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Shot himself in head

23. Signature Robert Lee Graham, M.D. M.D.
Medical Examiner.
Date signed 1-13-46

VS 151

Per: Howard J. Knieriem, M. D. X

G36429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G36429 Registered No.

write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 South Eaton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bellone

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 1-15-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director J. J. Feaby & Sons
(b) Address 1300 Eight St

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 15 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13/46 19 at 1:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 1/14/46

G36430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G36430 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	widowed

6 (b) Name of husband or wife John Kane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th 1864

8. AGE: Years	Months	Days	If less than one day
81	8	25	hr. min.

9. Birthplace St Mary's Co. Md
(Town, county, and state)

10. Usual Occupation cook

11. Industry or business

FATHER
12. Name W. J. Holt.
13. Birthplace

MOTHER
14. Maiden Name Ellen Butler
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Balto City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Gorsuch Ave Balto

19 (a) (Date received by Registrar) JAN 15 1946 (b) Huntington-Hilton Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1946, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946, to Jan 14 1946, and that I last saw her alive on Jan 13 1946.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 1/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G36431 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 Charlcote Road
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City of Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Charlcote Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE KEATING BOWIE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Richardson Bowie
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb-14-1881

8. AGE: Years 64 | Months 10 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Lawyer
11. Industry or business: Self

FATHER
12. Name: Reginald Bowie
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Blanche Crouch
15. Birthplace: Maryland

16 (a) Informant: Mr. C. Keating Bowie (son)
(b) Address: 106 Charlcote Road, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan/ /46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 105 W. North Avenue, City.

19 (a) 1-15-1946 (b) Huntington Nelligan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1946 at 6 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1931 to 19 and that I last saw him alive Dec 31 1945

Immediate cause of death: Coronary Artery Occlusion — Duration: 20 min

Due to: Coronary Artery

Due to: Arterio Sclerosis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Harold Lockard M. D.
Address 929 N Charles St Date Jan 15 46

VS 150

X (over)

G36432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 186a

G36432

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2638 Yorkway Rd (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Marvel (ANNIE ELIZABETH MARVEL)

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Martin L. Marvel
6 (c) If alive, give age *** years

7. Birth date of deceased (mo., day, yr.) February 25, 1862

8. AGE: Years	Months	Days	If less than one day
83	10	21 20	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name John Dukes
13. Birthplace Delaware

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Delaware

16 (a) Informant Mr. Clifford G. Marvel (son)
(b) Address Dundalk, Balto. Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-46 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 N. North Ave., Balto., Md.

(c) JAN 15 1946 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/ 1946, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1946, to 1/15 1946, and that I last saw h-e alive on 1/14 1946

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Hypostatic Pneumonia	
Due to Fractured Pelvis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1/1/46 at M
(c) Where did injury occur? Dundalk Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Fell out of Bed

23. Signature [illegible] M. D.
Address Date signed 1/17/46

VS 150 For Dr J.B. Davis, by Howard J. Madden, M.D. X

G36433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G36433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Ashland Ave (If rural give location)
(e) Citizen of foreign country? > (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Hoeky (HOCKY)

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Mary Hoeky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1892

8. AGE: Years 54 Months 9 Days 23 If less than one day hr. min.

9. Birthplace Europe (Town, county, and state)
10. Usual Occupation Bakery Store
11. Industry or business

FATHER
12. Name John Hocky
13. Birthplace Europe

MOTHER
14. Maiden Name Barbara Kleinhans
15. Birthplace Europe

16 (a) Informant Barbara Hocky
(b) Address 2001 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director South Broadway
(b) Address 900 N Caroline St. 5

19 JAN 15 1946 (b) (Date received by local registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1946, at 11:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1945 to Jan 13 1946, and that I last saw him alive on Jan 13 1946.

Immediate cause of death	Duration
Carcinoma of Lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Wheeler
Address [redacted] Date signed 1/15/46

VS 150

G36434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G36434 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Grayson St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Grayson St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Veronica Treherne

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry J. Treherne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1889

8. AGE: Years 56 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace N. Y. C., N. Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael J. McCarthy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Cox
15. Birthplace Ireland

16 (a) Informant Mr. Harry J. Treherne, Sr.
(b) Address 3025 Grayson St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (b)

Date of registry JAN 15 1946 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 6.15

20. DATE OF DEATH January 14, 1946, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to 1-17 1946. Saw that I last saw h[illegible] alive on 1-13 1946.

Immediate cause of death	Duration
Coronary thrombosis with obstruction of bowel.	? 3 mos.
Due to Coronary Occlusion	6 mos +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos G Oliver M. D.

Address 430 E Liberty Baltimore 2 Date signed 1-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170c

G36435

Registered No. G36435

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael or Mike Razamuen - RAZUMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
About 65			hr. min.

9. Birthplace Russian
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER	12. Name	? Razumaan
	13. Birthplace	Russian
MOTHER	14. Maiden Name	Not known
	15. Birthplace	Russian

16 (a) Informant John A. Gretkiewicz
(b) Address 423 S. Paca St

17 (a) Burial (b) Date thereof 1/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Ryson
Location Toney Run Rd. Govt

18 (a) Funeral director John A. Gretkiewicz
(b) Address 423 S. Paca St

19 (a) JAN 15 1946 Huntington, Williams, M.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Back: Fracture of Pelvis; Rupture of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 13, 1946 3/1 M.
(b) Where did injury occur? Gough St & Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No Auto
(d) Means of injury Pedestrian struck by
(e) Signature Robert Lee Slater M.D.
Medical Examiner.
Date signed 1-13-46

VS 151

X

G36436 G36435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Texas
(If outside city or town limits, write RURAL and give town)
(d) Street No. York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dolca C. Tracey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Wm. F. Tracey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1887

8. AGE: Years	Months	Days	If less than one day
58 57	9	8	hr. min.

9. Birthplace Balto Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James F. Howard
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Emma Hedwig
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs Wm. R. Tayers
(b) Address Cockeysville Md

17 (a) Burial (b) Date thereof Jan 16 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Poplar Grove
Location Cockeysville, Md

18 (a) Funeral director Landon M. Broth
(b) Address Govans, Md.

JAN 15 1946

19 (a) (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1946, to 1-15 1946, and that I last saw her alive on 1-15 1946

Immediate cause of death Asphyxia — Duration

Due to Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pulmonary edema & brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Gutter Bx.
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Jan 13, 1946 at 8 P. M
(c) Where did injury occur? Texas, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? No
(Specify type of place)
(e) Means of injury Coal gas from heater

23. Signature George R. Callum M. D.
Address Union Hosp. Date signed 1-15-46

VS 150 For Dr B. Steinbrecher by Howard J. Mueller, M.D. X

036437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered 036437

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2133 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EARNESTINE BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1886

8. AGE: Years	Months	Days	If less than one day
59	5	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William H. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace Md.

16 (a) Informant Mrs. Mary V. Dorsey
(b) Address 2133 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Baddle St.

19 (a) JAN 16 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1946, at 5A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/46 19 1/14/46 19 and that I last saw h[illegible] alive on 1/13/1946

Immediate cause of death Myocarditis — Duration 17 days

Due to Lupus Erythematosus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Ellis M. D.
Address [illegible] Date signed 1/16/46

VS 150

G36438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

Registered No. G36438

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Richmond Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Richmond Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Robert Crowe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bertha Brandt Crowe
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) July 22 1885

8. AGE: Years 60 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Lock Smith
11. Industry or business self

FATHER
12. Name William R. Crowe
13. Birthplace Balto

MOTHER
14. Maiden Name Clara Starr
15. Birthplace Balto

16 (a) Informant Mrs Bertha Crowe
(b) Address 521 Richmond Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Lelerick Funeral Home
(b) Address 200 E Orleans St

19 JAN 16 1946 (Date rec'd by local reg.) Huntington Williams M.D. (Signature of local reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1946 at 3 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1945 to 1/13 1946 and that I last saw h[illegible] alive on 1/12 1946.

Immediate cause of death	Duration
Coronary Occlusion	
Chronic Valvular Heart	
Due to arteriosclerosis	4 yrs
Due to	
Other Conditions Old healed Rib fx T. 7 & 8	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 2201 Clearfield Ave Date signed 1/16/46

VS 150

G36439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 C

G36439 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Chapelgate
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5251 St Charles Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Wiesner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27 1884

8. AGE: Years	Months	Days	If less than one day
61	1	16	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Cretor

11. Industry or business Crown Cork & Seal

FATHER
12. Name Dont Know
13. Birthplace

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Mrs Julia Krogman
(b) Address 5251 St Charles Ave

17 (a) Burial (b) Date thereof Jan 16 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Wm L Gruel Home
(b) Address 2008 Orleans

JAN 16 1946 Huntington Williams MD
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1946, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1945 to Jan 13 1946. and that I last saw h alive on 19

Immediate cause of death

	Duration
Myocardial Infarct Repeated	7 Wks
Due to Arteriosclerosis	
Due to	
Other Conditions Bronchitis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. P. Magna
Address 3326 Eastwood Ave Date signed 1/14/46

VS 150

636440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

636440 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BROADWAY + FAIRMOUNT
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Paul + 20th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARK, Mrs. MAIZE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: David Clark.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1873

8. AGE: Years 72 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Home maker
11. Industry or business none

FATHER
12. Name Sunderland, John.
13. Birthplace New Jersey

MOTHER
14. Maiden Name Burns, Mary
15. Birthplace Pennsylvania

16 (a) Informant Patient
(b) Address Here

17 (a) Burial (b) Date thereof 1/16/46
(Burial, ~~cremation~~, or removal) (month) (day) (year)
(c) ~~Cremation~~ Green Mount
Location Balto., Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1946, at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1946 to Jan. 15 1946 and that I last saw h.. alive on Jan. 14 1946

Immediate cause of death	Duration
Pulmonary edema	
Due to Myocardial failure	
Due to Coronary occlusion + Myocardial degen.	30 hrs.
Other Conditions Diabetes mellitus Hypertension Cerebrovascular dis. (Include pregnancy within 3 months of death)	

Date of operation none
Major findings of operation: 0
of autopsy Coronary occlusion + myocardial degen.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grant M. Farmer M. D.
Address CHURCH HOME HOSPITAL Date signed 1/15/46

94a

11-19-89

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33a

G36441 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 N. Eden St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Mary E. Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Henry Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 22, 1910

8. AGE: Years 35 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace: Harrisburg Pa. (town, county, and state)

10. Usual Occupation: Housewife.

11. Industry or business

FATHER
12. Name: Russia Clark
13. Birthplace: Va.

MOTHER
14. Maiden Name: Lula F. Smith
15. Birthplace: Hayesville Va.

16 (a) Informant: William Jones
(b) Address: 1034 N. Eden St.

17 (a) Disposition: Interment (Burial, cremation, or removal) (b) Date thereof: Jan. 16 1946 (month) (day) (year)

(c) Cemetery or crematory
Location: Harrisburg Pa.

18 (a) Funeral director: Robert L. Young
(b) Address: 504 N. Caroline St.

19 (a) JAN 16 1946 (Date rec'd by local reg.) Waiting for William Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1946, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1946 to Jan 14 1946 and that I last saw h[illegible] alive on Jan 14 1946

Immediate cause of death: Lobar Pneumonia — Duration 5 days

Due to:

Due to:

Other Conditions: Cirrhosis and Fractured Humerus — Duration 2 mths.

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Ralph L. Young, M.D.

Address 1424 E. Monument St. Date signed 1/15/46

X

G36442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170c

G36442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp 2 1/2 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 McCabe Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles H. Lane

3. (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mable V. Partial

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 - 1888

8. AGE: Years 57 | Months 6 | Days 12 13 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Taxi Driver

11. Industry or business Yellow Cab Co

FATHER
12. Name Charles V. Lane
13. Birthplace Dont Know

MOTHER
14. Maiden Name Emma ?
15. Birthplace Dont Know

16 (a) Informant Mable V. Lane
(b) Address 805 McCabe Ave

17 Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month), (day), (year)

(c) Cemetery or crematory Meadowridge
Location Washington Blvd.

18 (a) Funeral director John O. Hoppe
(b) Address 4201 Greenmount Ave

19 (a) Date received (b) Registrar

VS 151

JAN 16 1946

MEDICAL CERTIFICATION 35

20. DATE OF DEATH January 15, 1946, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed Fracture
of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-15-46 8 A. M. 16-2
(b) Where did injury occur? Calhoun & Lafayette Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Taxi & Truck Collision

23. Signature Robert Lee Gretter M.D.
Medical Examiner.
Date signed Jan. 15 1946

X

G36443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G36443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Kentucky Ave.
(c) Hospital or institution: 26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Kentucky Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen H. Astin

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ernest S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1884

8. AGE: Years	Months	Days	If less than one day
61		17	hr. min.

9. Birthplace Sweet Air, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Hilgartner
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Ernest S. Astin
(b) Address 3012 Kentucky Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Ave.

JAN 16 1946
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/ 1946, at 1.30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to Jan 14 1946, and that I last saw h[illegible] alive on Jan 14 1946

Immediate cause of death	Duration
Coronary occlusion	1 day
Due to Coronary heart disease	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Lee Thebaud M.D.
Address 4116 Northern Parkway Date signed 1/15/46

VS 150

GB6444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No. 636444

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3415 Cedardale Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Cedardale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clayton D. Beggs

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie May Beggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1874

8. AGE: Years	Months	Days	If less than one day
72	0	21	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Commission Merchant
11. Industry or business Owner

FATHER
12. Name John Beggs
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Martha E. Stoner
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Bessie M. Beggs
(b) Address 3415 Cedardale Rd. Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Ayes.

19 JAN 16 1946 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 14, 1946 at 3:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 13 1945 to JAN 14 1946 and that I last saw him alive on JAN 14 1946

Immediate cause of death	Duration
Angina Pectoris	10/13/45
Due to	
Uremia Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh D. Bubert M. D.
Address 1 E. Park Heights Ave Date signed 1/15/46

VS 150

C36445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C36445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 St. Paul Street
(c) Hospital or institution:
Madison Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lulu V. Householder

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 705-05-2909

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/17/1884

8. AGE: Years 61 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Relay, Md.
(Town, county, and state)

10. Usual Occupation Clerkial Ass. Supervision

11. Industry or business B. & O. R.R.

FATHER
12. Name Zebedee Householder
13. Birthplace W. Va.

MOTHER
14. Maiden Name Georgia V. Lusby
15. Birthplace Md.

16. (a) Informant Mr. William E. Householder
(b) Address 601 Regester Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

JAN 16 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/ 1946 at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15 1945 to Jan. 15 1946 and that I last saw h er alive on Jan. 12 1946

Immediate cause of death: Carcinoma of lungs - about — Duration: 10 mo.

Due to: Carcinoma of right breast — Duration: ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Dublet M.D.

Address 2220 Garrison Blvd. Date signed 1/16/46

VS 150

636446

BALTIMORE CITY HEALTH DEPARTMENT 1946 Registered No. 636446

CERTIFICATE OF DEATH

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 Chesterfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Chesterfield Ave -
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Walter M Downs

3 (b) If veteran, name war: 1

3 (c) Social Security Account No.: 217-03-7925

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gresham C.

6 (c) If alive, give age: 1896 years

7. Birth date of deceased (mo., day, yr.): Oct. 31, ~~1867~~ 1896

8. AGE: Years	Months	Days	If less than one day
49 ~~48~~	2	13 14	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Sect. Tres.

11. Industry or business: W. Baltimore Bldg. & Loan

FATHER
12. Name: Wm. F. Downs
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Emma Rhodes
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Gresham C. Downs
(b) Address: 3121 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Rd.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Ave.

19. JAN 16 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 January 1946, at 7:40 M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.
(Autopsy or Inquiry) (Autopsy or Inquiry)

	Duration
Immediate cause of death: Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: William S Helfrich M.D.
Medical Examiner
Date signed 15 January 46

(over)

G36447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G36447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 W. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 W. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLE GREEN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Charles Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1905

8. AGE: Years	Months	Days	If less than one day
40	6	7	hr. min.

9. Birthplace Boykin, S. C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Eddie Richardson
13. Birthplace South Carolina

MOTHER
14. Maiden Name Emma Lockridge
15. Birthplace South Carolina

16 (a) Informant Charles Green
(b) Address 403 Little George Street

17 (a) Burial (b) Date thereof I-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penne,. Ave.

19 (a) JAN 16 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1946, at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1946, to Jan 13 1946, and that I last saw her alive on Jan 12 1946

	Duration
Immediate cause of death Cerebral Apoplexy	3 days
Due to Arterial Hypertension	4 mths
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Lawrence M. D.
Address 1033 W. Lanvale St Date signed 1/14/46

VS 150

G36448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G36448

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 N. Pearl Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18. 1900

8. AGE: Years	Months	Days	If less than one day
45		26	25 hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas Butler
13. Birthplace Washington, D, C.

MOTHER
14. Maiden Name Ada Brooks
15. Birthplace Washington, D.C.

16 (a) Informant Nollie Charity
(b) Address 416 N. Pearl Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave.

19 JAN 16 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1946 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 12 1946 and that I last saw h alive on Jan 12 1946

Immediate cause of death Acute Coron Pneumonia — Duration 3 days Previously

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Stewart M. D.
Address 632 W. Franklin St Date signed Jan 12, 46

VS 150

G36449 BALTIMORE CITY HEALTH DEPARTMENT G36449

CERTIFICATE OF DEATH

Registered No. 163 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 N. Appleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 N. Appleton St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Kline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Sol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years: 33 | Months | Days | If less than one day: hr. min.

9. Birthplace Cincinnati Ohio
(Town, county, and state)

10. Usual Occupation Sales Lady

11. Industry or business

FATHER
12. Name Louis Spesler
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta
15. Birthplace Russia

16 (a) Informant Yetta Spesler
(b) Address 1736 N Appleton St

17 (a) Burial (b) Date thereof 1-16-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Herring Run Lawn

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E. Oliver St

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 16 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1946 at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coma
Barbiturate Poisoning
Due to Sodium Pentobarbital

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 14 1946 M.
(b) Where did injury occur? 2809 Cold Spring Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Pentobarbital

23. Signature Paul A. Fratantoni M.D.
Medical Examiner.
Date signed Jan 15 1946

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 636450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. CALVERT ST.
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15½ HRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 W. GARRISON AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL SELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-15-46

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 17 hr. 30 min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

FATHER
12. Name PAUL SELL
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden Name MARTHA FREEDMAN
15. Birthplace BALTIMORE, MD.

16 (a) Informant PAUL SELL
(b) Address 2817 W. GARRISON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location Phila. Rd. & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) 1-16-1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16-46 1946, at 4:31 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1946 to 1-16 1946 and that I last saw her alive on 1-16 1946

Immediate cause of death ATELECTASIS — Duration 17½ HRS

Due to PREMATURITY - 7½ MOS. GESTATION, TWIN PREGNANCY

Due to WGT. 3'12½"

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Reall M.D.
Address Mercy Hospital Date signed 1-16-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36451 BALTIMORE CITY HEALTH DEPARTMENT 30 G36451

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1051 Argyle ave
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1051 Argyle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Dyson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, ~~widowed~~, or divorced. Married

6 (b) Name of husband or wife Grace Dy.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1888

8. AGE: Years 57 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Prince George Co. Md
(Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER 12. Name Stevens Dyson
13. Birthplace Md.

MOTHER 14. Maiden Name Betty
15. Birthplace Md.

16 (a) Informant Grace D. Dyson
(b) Address 1051 Argyle Ave

17 (a) Burial (b) Date thereof Jan. 16, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Mem Pk
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Geo. W. Stallard
(b) Address 1631 Druid Hill Ave

19 (a) JAN 16 1946 (b)
(Date received by registrar) Health Officer for Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945, to Jan. 12 1946 and that I last saw h alive on Jan 7 1946.

	Duration
Immediate cause of death Coronary Thrombosis	1/2 day
Due to Luetic Aortitis	8 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. P. Johnson M. D.
Address 403 McCulloh Date signed 1-14-46

636452

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 176

636452 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Balmeur St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Hurtt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Helen A.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1885

8. AGE: Years 60 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Green Bay Va (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name Silas Hurtt
13. Birthplace Green Bay, Va

MOTHER
14. Maiden Name Mary
15. Birthplace Green Bay, Va

16 (a) Informant Helen Hayes Hurtt
(b) Address 123 Balmeur Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md.

18 (a) Funeral director Geo. A. Hartman
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) JAN 16 1946 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1946 at 9 20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of neck; Fracture of ribs; Contusion & Fracture of Humerus, right

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 30, 1945 M.
(b) Where did injury occur? Bethlehem Steel, Sparrows Point
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Caught in machinery
23. Signature Robert Lee Gratton M.D. Medical Examiner.
Date signed Jan 13 1946

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36453 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 Roberts Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Roberts Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD Willis

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-6760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	

6 (b) Name of husband or wife. None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1888

8. AGE: Years	Months	Days	If less than one day
57	10	11	hr. min.

9. Birthplace Gloucester Co. Va
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Farmer Willis
13. Birthplace Va

MOTHER
14. Maiden Name Betty Baytes
15. Birthplace Va

16 (a) Informant Edward Willis Jr.
(b) Address 1128 N. Lafayette Ave

17 (a) Burial (b) Date thereof Jan. 17, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cem. Co.
Location Balto. Co. Md.

18 (a) Funeral director Wm. Geo. A. Hall & Son
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

JAN 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/46 19 at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 1/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36454 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bons Secours Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 N. Patterson Pk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Butt

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George H. Butt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 22, 1895

8. AGE: Years	Months	Days	If less than one day
50 yrs	1	23	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: housewife at home
11. Industry or business

FATHER
12. Name: John H. Strickroth
13. Birthplace: Germany

MOTHER
14. Maiden Name: Maria K. Weise
15. Birthplace: Germany

16 (a) Informant: Geo. H. Butt - Husband
(b) Address: 223 N. Patterson Pk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18, 46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: Charles E. Schlumunek
(b) Address: 2601-03 E. Madison Street.

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Williams

JAN 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-15 1946, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1946 to 1-15 1946, and that I last saw h.er alive on 1-15 1946.

Immediate cause of death: Acute Dilatation of Heart — Duration: 1 hr.

Due to: Chronic Coronary Heart Disease

Due to: Spinal Anesthesia

Other Conditions: Hypertensive C-V Disease
(Include pregnancy within 3 months of death)

Date of operation 1-15-46

Major findings of operation: only made skin incision

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/1
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence 1-15-46 at 11:45 M
(c) Where did injury occur? Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hosp While at work? (Specify type of place) Operating Room
(e) Means of injury: Death during administration of anesthetic

23. Signature: Richard C. Hayden M. D.
Address: Bons Secours Date signed 1-16-46

Robert Lee Bratton M.D. Jan 16 1946

636455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

831

636455 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Pennsylvania Ave
(c) Hospital or institution: Dst

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 1900

8. AGE: Years 45 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER
12. Name Albert Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Charity Priemes
15. Birthplace Md.

16 (a) Informant Mary Hall
(b) Address 1119 ½ Penn. ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Adolphus Holstead
(b) Address 845 Eastern Ave

19 (a) JAN 16 1946 (Date rec'd by registrar) (b) Huntington & Pulaski Sts Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1946, 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/16/46

G36456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G36456 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 Division St
(c) Hospital or Institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Edmondson Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia E Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Columbus Woods

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-5-10

8. AGE: Years 35 | Months 7 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Mississippi
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Henry Lamyh
13. Birthplace Mo.

MOTHER
14. Maiden Name Georgia Burks
15. Birthplace Miss

16 (a) Informant Columbus Woods
(b) Address 1531 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) [illegible] (b) [illegible] for Williams
JAN 16 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-1946, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1946 to 1-12 1946, and that I last saw h[illegible] alive on 1-12-1946

Immediate cause of death Intestinal Obstruction - Mesenteric Thrombosis - peritonitis. — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/11/46

Major findings of operation: Gangrenous Front - Jejunum, Retraction of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature R. C. Jackson M.D.
Address 1601 Eutaw Place 1/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9

G36457 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd
(c) Hospital or institution: Sydenham Hospital 18
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 6
(e) Length of stay in Baltimore (~~yrs.~~ mos., ~~or days~~) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 W. Fayette
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Pringle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: non

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 2-11-85 11 2 45

8. AGE: Years | Months: 2 | Days: 3 13 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Sept. Pringle
13. Birthplace Sumpter S.C.

MOTHER
14. Maiden Name Blanche
15. Birthplace

16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) JAN 16 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-46 1946, at 12:30 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9- 1946 to 1-15- 1946, and that I last saw h.er alive on 1-15- 1946.

Immediate cause of death Pneumonia, Bronchial — Duration

Due to Pat. T.B.: Pneumonia

Due to

Other Conditions ? Heart failure.

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melchiah Sprague M. D.
Address Sydenham Hosp. Date signed 1-15-46

Huntington Williams, M.D.

G36458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. G36458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2331 E. Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2331 E. Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schuppener

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Rosanna Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 - 1861

8. AGE: Years 84 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Schuppener
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Koehler
15. Birthplace Germany

16 (a) Informant Harry L. Schuppener
(b) Address 328 Park Ave. Frederick Md.

17 (a) Burial (b) Date thereof 1 / 17 / 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St - 13

19 JAN 16 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14- 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 15 1946 and that I last saw him alive on Jan 14 1946

Immediate cause of death

Duration

Hypertension 2 wks

Due to Cardiac Decompensation

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Williams Jr. M.D.
Address 16 W. Madison St. Date signed 1-16-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

636459 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosaria Testa

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Antonio Testa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 21 1856

8. AGE: Years	Months	Days	If less than one day
89	10	24 23	hr. min.

9. Birthplace Ielsi Italy
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business home

FATHER
12. Name Giuseppe Perna
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Pesca
15. Birthplace Italy

16 (a) Informant Antonio Testa (Husband)
(b) Address 1205 Poplar Grove St.

17 (a) Burial (b) Date thereof Jan. 17 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Parlay St.

19 (a) JAN 16 1946 (b) Huntington Williams M.D.
(Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1946, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1946, to 1-14 1946, and that I last saw h.e alive on 1-14 1946

Immediate cause of death	Duration
Hypertensive Heart Disease with Congestive Failure	? years 6 wks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo Ashman M. D.
Address 1201 Poplar Grove St Date signed 1-15-46

VS 150

G36460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G36460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1344 Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Cleveland (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Thomas Baker

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Robert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/15/1894
8. AGE: Years 51 | Months 7 | Days 28 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ella Williams
15. Birthplace Baltimore, Md.

16 (a) Informant Ella Gray (Daug.)
(b) Address 1344 Cleveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) JAN 16 1946 (Date rec'd, reg'd.) (b) Huntington Williams MD (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1946, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to 13 Jan 1946 and that I last saw ~~deceased~~ Jan 13 1946.

Immediate cause of death Myocarditis, Chronic — Duration

Due to

Due to

Other Conditions Hypertension Carcinoma Vesicalis Renal Insuf.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

At autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? — (Specify type of place)
(e) Means of injury —

23. Signature John P. Ulrich, Jr.
Address 122 Wade Blvd Date signed 15 Jan 46

VS 150

G36461

AB-87076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G36461

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospirals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr- 9mos-22days
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vanilla Coward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7- 1908

8. AGE: Years	Months	Days	If less than one day
37	3	7	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Faisom Sampson (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Georgia Boyd (D)
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals(Recor
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memil Pk.
Location Balto. County, Md

18 (a) Funeral director Chas. L. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Jan 16 1946 (Date received by registrar) (b) Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14- 1946 at 2.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1944 to 1-14- 1946, and that I last saw her alive on 1-14- 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to: Tuberculous Entero-Colitis

Due to:

Other Conditions: Vena Caval Thrombosis Hydronephrosis Left
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Herbert R. Boreland Jr. M. D.
Address Balt. City Hosp. Date signed 1/14/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 636462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts
(c) Hospital or Institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2165 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. LeRoy Clark

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena B. Clark
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6/16/1890

8. AGE: Years 55 | Months 6 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business Baltimore City Fire Dept
12. Name of FATHER Samuel Clark
13. Birthplace Md
14. Maiden Name of MOTHER Beulah Parks
15. Birthplace Md
16 (a) Informant Lena B. Clark
(b) Address 2165 W. Fayette St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/46 (month) (day) (year)
(c) Cemetery or Crematory Westview
Location Baltimore, Md
18 (a) Funeral director J. D. Heyman & Son
(b) Address 1854 W. Pratt St
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1946, at 6:10 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/1946, to 1/15 1946, and that I last saw h[illegible] alive on 1/15 1946.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertensive C.V.D.	
Due to	
Other Conditions Arteriosclerosis Coronary Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Hydrothorax, passive congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. L. Shichel Jr. M. D.
Address Bon Secours Hosp. Date signed 1/15/46

VS 150

JAN 16 1946

X

636463 ~~636463~~ ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. 636463

~~Patterson Park~~ ~~Fredrick Ave~~ ~~Sanitarium~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5023 Wilkins Ave
(c) Hospital or institution: ~~Home~~
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5023 Wilkins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah J. Kenney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1865

8. AGE: Years 80 | Months 4 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual Occupation Homemaker

11. Industry or business

FATHER
12. Name Patrick Kenny
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Frances
15. Birthplace Ireland

16 (a) Informant Mrs. Sarah G. Bond
(b) Address 5023

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18, 1946 (month) (day) (year)
(c) Cemetery or crematory St Josephs
Location Irvine, Maryland

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md

19 (a) ..... (b) Huntington Ave Registrar
(Date received by registrar)

JAN 19 1946

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1946, at 9:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Jan 16 1946, and that I last saw h[er] alive on Jan 15 1946.

Immediate cause of death Carcinoma of Colon — Duration

Due to — Duration

Due to — Duration

Other Conditions Senility — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A H Carmichael M. D.
Address 4709 Fred Ave Date signed 1/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36464 G36464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Dundalk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Michel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/14/46

8. AGE: Years | Months | Days | If less than one day 3 hr. 10 min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Charles H. Michel
13. Birthplace Phila. Pa.

MOTHER 14. Maiden Name Mary Mayfair
15. Birthplace Phila. Pa.

16 (a) Informant Mrs. Grace Michel
(b) Address 1823 Dundalk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) (Date received by registrar) (b) Registrar

JAN 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1946 at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/14 1946 to 1/17 1946 and that I last saw h[illegible] alive on 1/17 1946.

Immediate cause of death: Cardio Respiratory failure
Due to: Prematurity
Due to: 20 week pregnancy
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Luck Jr.
Address St Josephs Hosp Date signed 1/16/46 M.D.

G36465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G36465 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Ridgecroft Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Ridgecroft Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Stamm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh.	Widow

6 (b) Name of husband or wife Joseph A. Stamm (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1870

8. AGE: Years	Months	Days	If less than one day
75	8	15	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Francis Beck
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Charles R. Stamm
(b) Address 3906 Ridgecroft Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Registrar

JAN 16 1946

Huntington-Hillcrest, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1945 to Jan 16 1946 and that I last saw h[illegible] alive on Jan 16 1946

Immediate cause of death	Duration
Pneumonia	about
Due to General Arteriosclerosis	3 years
Due to Carcinoma of Breast	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation April 1944
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Kane Trompetter M. D.
Address Lena Hardy-Hyattsville Md. Date signed 1-16-46

G36466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G36466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 W. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d 8 h
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E. Edward Riggin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1877

8. AGE: Years	Months	Days	If less than one day
68	5		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John B. Riggin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine M. Phillips
15. Birthplace Baltimore, Md

16 (a) Informant Mr. Harvey A. Riggin
(b) Address 908 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Bowen & Son
(b) Address 901-03 W. Fallsway
(Signature of local registrar) Waiting for Williams

JAN 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1946, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Jan. 1946, to 15 Jan. 1946, and that I last saw him alive on 15 Jan. 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	1 Day
Due to Intracerebral hemorrhage	
Due to	
Other Conditions Carcinoma of Stomach	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar Tomorilla M.D.
Address 260 W. Lombard Date signed 16 Jan 46 M. D.

Tomorilla 937

G36467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36467 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2327 W. North Ave.
(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 W. North
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Estelle Brickman

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Arthur O. Brickman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 10 1865

8. AGE: Years 81 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace Harrisburg Penna.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry Paul Owens
13. Birthplace Penna.

MOTHER
14. Maiden Name Sallie J. Owens
15. Birthplace Penna.

16 (a) Informant Mrs. Anna M. Souder (Wife)
(b) Address 2327 W. North Av

17 (a) Burial (b) Date thereof 1-17-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 148 N. NORTH AVENUE

19 (a) (b)
(Date received by registrar) Registrar

JAN 10 1946
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1946 at 12:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1945 to Jan. 15 1946 and that I last saw her alive on Jan. 15, 1946

Immediate cause of death: Cerebral Thrombosis — Duration 6½ hours

Due to Arteriosclerotic Cerebro-Vascular Disease, with pneumonia — ? ?

Due to Cerebral Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. Lerner, M.D.
Address 2401 W. North Ave. Date signed 1/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution:
SINAI HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALAN WHITEHILL.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1873

8. AGE: Years	Months	Days	If less than one day
72		17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Salesman.
11. Industry or business

FATHER
12. Name Israel Whitehill,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rachel Mandelbaum,
15. Birthplace Germany.

16 (a) Informant Mr. Milford Whitehill,
(b) Address 3203 N. Charles St.

17 (a) Burial (b) Date thereof 1/17/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 (a) (b) Huntington Williams
(Date rec'd by registrar)

JAN 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1946, at 3.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 7 1946 to January 15 1946, and that I last saw him alive on January 15 1946.

Immediate cause of death Arteriosclerotic Heart Disease, Hypertensive cardio-vascular Renal Lesions — Duration 10 years

Due to

Due to

Other Conditions Myocardial Infarction, old & new, anemia & pellagra.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial Infarction, Heart etc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Kirschbaum M. D.
Address Sinai Hospital Date signed 1/15/46

G36469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G36469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eutaw Place & Wilson St. Marlborough Apts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. Marlborough Apts.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME PAULINE GOLD

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1855.

8. AGE: Years	Months	Days	If less than one day
90	10	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Abraham Gold,

13. Birthplace Germany.

MOTHER 14. Maiden Name Babette Hutzler,

15. Birthplace Germany.

16 (a) Informant Mr. Lee I. Hecht,

(b) Address Union Trust Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 17/46. (month) (day) (year)

(c) Cemetery or crematory Har Sinai

Location Balto. Md.

18 (a) Funeral director [illegible]

(b) Address 1902 Eutaw Place.

19 (a) 1 6 1946 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15th. 1946, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945, to Jan 13 1946, and that I last saw her alive on Jan 13 1946.

Immediate cause of death	Duration
Generalized arteriosclerosis	
Due to senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Richard D Hecht M.D.

Address Marlborough Apts. Date signed 1/15/46

636470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

636470 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3340 Caton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3340 Caton Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie H. Thomas

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: James C. Thomas
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 22, 1886

8. AGE: Years 59 | Months 8 | Days 24 | If less than one day: hr. 3 min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Thomas Hipsley
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Kate Knott
15. Birthplace: Maryland

16 (a) Informant: Vernon E. H. Thomas
(b) Address: 3340 Caton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-18-46 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore Md.

18 (a) Funeral director: George L. Penwal
(b) Address: 2101 Frederick Avenue

19 (a) JAN 17 1946 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150.

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15, 1946, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Dec 1945 to 15 Jan 1946, and that I last saw her alive on 14 Dec 1946

Immediate cause of death	Duration
Coronary Occlusion	3 days
Due to: coronary sclerosis	
Due to:	
Other Conditions: Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Nathan Rosenau M. D.
Address: 206 S. Gilmor St Date signed: 1-16-46

9-4a

G36471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G36471

Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Pr. Georges Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Matthews
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Williams
15. Birthplace Md.

16 (a) Informant George Matthews
(b) Address Laurel, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof Jan 19 1946
(month) (day) (year)
(c) Cemetery or crematory Milinkuk
Location Prince Georges Co

18 (a) Funeral director [redacted] Ridgely & Selby
(b) Address Laurel, Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JAN 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1946 at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946, to Jan 16 1946 and that I last saw h-r alive on 1-16 1946

Immediate cause of death	Duration
Heart failure.	
Due to Hypertension Hemorrhage	
Due to Ca of stomach	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-13-46
Major findings of operation: Large Carcinoma of stomach
of autopsy:

PHYSICIAN
Underline the death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas E. Buddemeier M. D.
Address Louisville, Ky. Date signed 1-16-46

636472

CWK-98252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 636472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Refer to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Trappe Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bulla, Baby Girl-(Elizabeth)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3-1946

8. AGE: Years	Months	Days	If less than one day
0	0	7	hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hobart C. Bulla
13. Birthplace North Carolina

MOTHER
14. Maiden Name Elizabeth Perrow
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 1-12-46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1946 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1946 to Jan. 10 1946 and that I last saw h er alive on Jan. 10 1946

	Duration
Immediate cause of death: Prematurity	7 days
Intracranial Hemorrhage	
Due to: Lupus	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard A. Kelly M.D. (M.D.)
Address Balto. City Hosp. Date signed 1-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G36473

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore.
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 33rd & Calvert. (If rural give location) 25 E. 21st St.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Corbett (White)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single.

6 (b) Name of husband or wife Mrs. T. H. Corbett.
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 1-9-46

8. AGE: Years	Months	Days	If less than one day
0	0	0	10 hr. 9 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None.

FATHER
12. Name Mr. T. H. Corbett
13. Birthplace West Virginia

MOTHER
14. Maiden Name Kay Mullen
15. Birthplace West Virginia.

16 (a) Informant Mrs. T. H. Corbett.
(b) Address 25 E. 21st St., City-18

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Disposed of by hospital

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams,

JAN 17 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-9 1946 to Jan 10 1946, and that I last saw her alive on Jan 10 1946.

Immediate cause of death	Duration
Fetal Prematurity 5 hrs.	
Due to Twins, pregnancy	
Due to Hydramnios	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. K. M. Hamm M. D.
Address Date signed

(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36474

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 N. Calvert (If rural give location)
256 E 21st St.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) **FULL NAME** Baby Girl Corbett (twin)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S. Wife
6 (b) Name of husband or wife: Mrs. T. H. Corbett
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 1/9/46

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day 10 hr. 20 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business None.

FATHER
12. Name Mr. T. H. Corbett.
13. Birthplace West Virginia.

MOTHER
14. Maiden Name Kay McAllen
15. Birthplace West Virginia

16 (a) Informant Mrs. T. H. Corbett.
(b) Address 256 E. 21st St. City-16

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location Disposed of by hospital

18 (a) Funeral director .....
(b) Address .....

19 (a) JAN 17 1946 (b) Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1946, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1946 to Jan 11 1946, and that I last saw her alive on Jan 11 1946.

Immediate cause of death	Duration
Immaturity - 3 lbs 10 oz.	
Due to Twin pregnancy	
Due to Hydramnios	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Leon M. Hess M. D.
Address ..... Date signed .....

(over)

G36475 HEALTH DEPARTMENT—CITY OF BALTIMORE G36475

CERTIFICATE OF DEATH

1. PLACE OF DEATH — Registered No. 1600

CITY OF BALTIMORE: (No. Volunteers of America Hospital St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME James Joseph Garrity — If U. S. Veteran specify WAR

(a) Residence: No. 3521 Buena Vista Ave St., Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Jan 16, 46

7. AGE Years	Months	Days	If LESS than 1 day 10 hrs. 20 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME William Garrity

14. BIRTHPLACE (city or town) (State or country) Balto Md

MOTHER

15. MAIDEN NAME Thelma Shay

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Mrs Garrity (Address) 3521 Buena Vista Ave.

18. BURIAL, CREMATION, OR REMOVAL Place Mount Pleasant Date 1/17/46

19. UNDERTAKER Chipman Lee & Donaldson (Address) 5615-17 Chestnut Ave

20. FILED JAN 17 1946 Huntington Williams, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 16, 1946

22. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1946 to Jan 16, 1946

I last saw him alive on Jan 16, 1946 Death is said to have occurred on the date stated above, at 2 20 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral and pharyngeal hemorrhage	about

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) J Hudlin M.D., M. D.

(Address)

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V8 9

G36476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 ✓

Registered No. G36476

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 E. Balto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Seal Silver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Leng

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Chang
15. Birthplace Russia

16 (a) Informant Leng Silver
(b) Address 2109 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila. Rd + Hamilton Ave

18 (a) Funeral director Vasis Lewis Inc
(b) Address 1439 E. Balto St

19 (a) JAN 17 1946 (Date rec'd by registrar) (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16-46 19 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 16 1946, and that I last saw him alive on Jan 16 1946

Immediate cause of death Coronary Thrombosis — Duration 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon

Address 129 E Biway Date signed 1-16-46

G36477 ✓ over G36477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Bell Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE GINSBERG

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MORRIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years 35 | Months | Days | If less than one day: hr. min.

9. Birthplace: BALTO MD
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business

FATHER
12. Name: FRANK
13. Birthplace: RUSSIA

MOTHER
14. Maiden Name: DORA
15. Birthplace: RUSSIA

16 (a) Informant: HOSPT RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-46 (month) (day) (year)
(c) Cemetery or crematory: BETH TFILOH
Location: WINDSOR MILL RD

18 (a) Funeral director: JACK LEWIS INC
(b) Address: 2100 EUTAW PL.

19 JAN 17 1946 (Date rec'd by local reg.) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1946, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1946, to 1/16 1946, and that I last saw her alive on 1/15 1946.

Immediate cause of death: Heart failure — Duration

Due to: Arteriosclerotic heart dis.

Due to:

Other Conditions: Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Alvin D. Rubin M. D.

Address: Sinai Hosp. Date signed 1/16/46

VS 150

937

JL - 6486478 — 636478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D — Registered No. 636478 (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 6 - 29
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Whitehead

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1859

8. AGE: Years	Months	Days	If less than one day
86	9	26	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Gaven
13. Birthplace Spain

MOTHER
14. Maiden Name Annie Odonell
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) JAN 17 1946 (b) [illegible] Registrar
(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1946 19 , at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1943 to Jan. 15 1946, and that I last saw her alive on Jan. 15 1945

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address 82 E. 18. Date signed 1/17/46

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

636479 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira & Linden
(c) Hospital or institution: Mosgrove General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2767 Baker st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary De Ved

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ George L. De Ved

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16th 1905

8. AGE: Years	Months	Days	If less than one day
40	9	0	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Asst Babs Jail Hospital

FATHER 12. Name Frank Arrington
13. Birthplace Md

MOTHER 14. Maiden Name Margaret Kreuzbaugh
15. Birthplace Md

16 (a) Informant Edward Harrington Brooks
(b) Address Marriottsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Springfield
Location Sykesville Md.

18 (a) Funeral director Harry Weer
(b) Address Sykesville Md

19 (a) JAN 17 1946 (b) Arrington for Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1946 at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1945 to 1-16 1946, and that I last saw h~~e~~r alive on 1-15-1946

Immediate cause of death	Duration
(a) Hemorrhage from esophageal varices	
Due to (b) Cerrhosis of the liver,	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature C. M. Audiel M. D.
Address Mosgrove General Hosp. Date signed 1-16-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36480

484907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G36480

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County.....
(c) City or town Alexandria (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 5, Box 706 Pine Hill Farm (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Herbert Revis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-1-43

8. AGE: Years	Months	Days	If less than one day
2.	3	15	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Herbert Revis
13. Birthplace D.C.

MOTHER
14. Maiden Name Betty Downder.
15. Birthplace D.C

16 (a) Informant Rel. unk.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20, 1946 (month) (day) (year)
(c) Cemetery or crematory.....
Location Washington, D.C.

18 (a) Funeral director S.H. Hines Co.
(b) Address Washington, D.C.

19 (a) JAN 17 1946 Registered by registrar Registrar

Huntington Hillcrest, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-16-1946 at 8.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-7 1945, to Jan-16 1946, and that I last saw him alive on Jan-16 1946.

Immediate cause of death Candida Decompensation — Duration .....

Due to Tetralogy of Fallot — .....

Due to ..... — .....

Other Conditions Antral Thrombosis — .....
(Include pregnancy within 3 months of death)

Date of operation January 14 1946

Major findings of operations Tetralogy of Fallot

of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature D. A. Cosby M. D.
Address The Johns Hopkins Hospital Date signed Jan 16 1946

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

636481 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4314 Curtis Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 Curtis Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KARALIS VRBUS

3 (b) If veteran, name war /
3 (c) Social Security Account No. /

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Vernica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Retire
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant ANNA GARPSTAS
(b) Address 4314 Curtis Ave

17 (a) Burial (b) Date thereof Jan 19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Crundell County

18 (a) Funeral director Joseph Karamakas Son
(b) Address 600 Wash. Blvd

19 (a) (Date rec'd by registrar) JAN 17 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946; at 8 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Jan 15 1946 and that I last saw h/ alive on Jan 4 1946.

Immediate cause of death	Duration
Complete Heart Block	
Due to Arterio-Sclerotic Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Lantz M.D.
Address 320 Patapsco Ave Date signed 1/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 636482

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) Same Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Edmondson Ave.
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Ollie Doles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 JAN 17 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5-1946, at 12 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular renal disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Benedict Stasulis M.D.
Medical Examiner.
Date signed 1-9-46

(OOA) 5224 X

G36483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G36483

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Edmondson Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Fray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/7/46

8. AGE: Years | Months | Days | If less than one day 12 hr. min.

9. Birthplace Balt., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David B. Fray
13. Birthplace

MOTHER 14. Maiden Name Betty Wallamayer
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1946 to 1/7 1946, and that I last saw her alive on 1/7 1946

Immediate cause of death	Duration
Premature twin - 2 lbs.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Marks M. D.
Address Univ Hosp Date signed 1/7/46

VS 150

5223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 636184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Carolina St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luther Winfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years: 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/46 (month) (day) (year)
(c) Cemetery or Crematory Mt. Calvary Cem
Location Roger Sherlep

18 (a) Funeral Director Johns Hopkins Medical School JAN 15 1946
(b) Address 1412 E. Preston St

19 JAN 17 1946 Commissioner of Health
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1946, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D. Medical Examiner.
Date signed 1/16/46

F322 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

G36485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

G36485 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4200 Glenmore Ave
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Glenmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth H Scheerer

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Gottlieb Scheerer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1876

8. AGE: Years	Months	Days	If less than one day
69	1	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name -- Holzshauer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Evelyn Melville
(b) Address 4200 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Lasalm Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date received by registrar) (b) Registrar

JAN 17 1946 Huntington Williams, M.D.

JVS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946 at 8.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1946 to 1/15 1946. and that I last saw h[illegible] alive on 1/13 1946.

Immediate cause of death	Duration
Myocardial failure	3 wks
Due to Arteriosclerosis	undetermined
Due to Diabetes Mellitus	28 yrs.
Other Conditions Cataract Rt eye Surgical absence left eye	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. T. Battaglia M. D.
Address 5829 Belair Rd Date signed 1/15/46

636486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

636486 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Lafayette & Callum
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5801 Winner Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L Bland (Edward L. Bland)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-1858

8. AGE: Years	Months	Days	If less than one day
87	1	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm J Bland
13. Birthplace Va

MOTHER
14. Maiden Name Mary Ellen Dennis
15. Birthplace Va

16 (a) Informant Mr. Arthur V. Hooper
(b) Address 100 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 JAN 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1946, at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9am 1-5 1945, to 1-15 1946, and that I last saw him alive on 1-15 1946.

Immediate cause of death	Duration
Cachexia	
Due to Circumstances	
Due to Carcinoma of lung	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. K. Kenyon M. D.
Address Franklin Square Hosp Date signed 1-16-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 Registered No. G36487

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Annapolis Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Annapolis Rd.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Robert Patterson Sr.

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-01-8295

4. Sex Male W | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1874

8. AGE: Years 71 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Belfast, Ireland (Town, county, and state)

10. Usual Occupation Master Mechanic

11. Industry or business Carr Lowry Glass Co.

FATHER
12. Name William Patterson
13. Birthplace Ireland

MOTHER
14. Maiden Name Marie Patterson
15. Birthplace Ireland

16 (a) Informant Mr. Howard W. Patterson
(b) Address 3201 Avon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) JAN 17 1946 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1946 to Jan 15 1946 and that I last saw him alive on Jan 15 1946

Immediate cause of death	Duration
Coronary Thrombosis	1 dy
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 3201 Avon Ave Date signed 1/17/46

Huntington Williams, MD

G36488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

G36488

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fred. Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roger M. Bell

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-9347

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mabel E Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1899

8. AGE: Years	Months	Days	If less than one day
46	6	24	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Bridge Carpenter

11. Industry or business Balto Transit

FATHER
12. Name Luther Bell
13. Birthplace Va.

MOTHER
14. Maiden Name Clara Bell
15. Birthplace Va

16 (a) Informant Mabel Bell
(b) Address Ellicott City Md

17 (a) Burial (b) Date thereof 1-21-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Morgan Chapel
Location Woodbine Md

18 (a) Funeral director T. C. Higinbotham
(b) Address Ellicott City Md

JAN 17 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1946 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSHION OF DEATH Compound skull fracture Contusions and laceration of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-16-46 Balto. Co. P.M.
(b) Where did injury occur? Found 81 rods East near Ellicott City
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Pedestrian struck by street car

23. Signature Dennis Autenrieth M.D. M.D.
E. Howard J. Mencimer M.D.
Date signed 1-17-46

G36489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1606

G36489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Gibbons Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Howard Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/46

8. AGE: Years	Months	Days	If less than one day
		1/4	hr. 20 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Christian F. Clark
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Teresa M. Polak
15. Birthplace New Jersey

16 (a) Informant Christian F. Clark
(b) Address 3605 Gibbons Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Frederick Ave

18 (a) Funeral director Geo H. Lembach
(b) Address 25 N Lyndhurst St

19 (a) JAN 17 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1946, at 1:10 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 1/16 1946 to 1/16 1946 and that I last saw him alive on 1/16 1946

Immediate cause of death
Asphyxia
Due to Prolonged breech delivery
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Lloyd Jr. M.D.
Address St. Josephs Hospt Date signed 1/16/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

G36490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

G36490 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1248 Northview Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1248 Northview Road (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William Tylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Vilma Tylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1884

8. AGE: Years 61 | Months 3 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Jeweler

11. Industry or business

FATHER 12. Name Bernard Tylor
13. Birthplace Holland

MOTHER 14. Maiden Name Isabelle —
15. Birthplace N.J.

16 (a) Informant Mrs. Vilma Tylor
(b) Address 1248 Northview Rd (Residence)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Philip Henry Ford
(b) Address 2024 Orleans St

19 (a) JAN 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 January 1946, at 11:20 P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Autopsy or Inquiry) thereon and from the evidence obtained by said Autopsy (Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William G. Hatfield M.D. (Medical Examiner)
Date signed 16 January 46

VS C

G36491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52D

Registered No. G36491

CWK-95591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- 23
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 Division Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Flenora Lewis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bunie Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2-1889

8. AGE: Years 56 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Lewis
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Kellam
15. Birthplace Virginia

16 (a) Informant Record-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pennsylvania Ave.

19 (a) JAN 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1946, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1945 to Jan. 15 1946, and that I last saw h alive on Jan. 15 1946

Immediate cause of death Cerebral Circulatory Collapse
Due to Cancer of Bladder
Due to
Other Conditions Carcinomas of Bladder & Metastases
(Include pregnancy within 3 months of death)

	Duration

Date of operation 9/27/45
Major findings of operations Cancer
of autopsy Cancer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Moran
Address Post Cozz H. Date signed 1/16/46 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G36492

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 71
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Silberzahn

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William G. Silberzahn
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Oct 17 1870

8. AGE: Years	Months	Days	If less than one day
75	3	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Philip C. Fritz
13. Birthplace Germany.

MOTHER
14. Maiden Name Clara Keil
15. Birthplace Germany.

16 (a) Informant William G. Silberzahn
(b) Address 1233 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

16 (a) Funeral director Mrs. John W. Teufel & Son
(b) Address 801 W Fayette St

JAN 17 1946 (Date rec'd by registrar) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946, at 10 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Dec 1945 to 15 Jan 1946 and that I last saw h[illegible] alive on Jan 15 1946

Immediate cause of death Bronchopneumonia — Duration 4 days
Due to Influenza Primary
Due to
Other Conditions Hypertension, Arteriosclerosis, Cardiac troubles Renal Disease — 4 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Ulrich Jr. M.D.
Address 1227 Wash Blvd Date signed 16 Jan 46

VS 150

107

G36493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36493 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital,
(d) Length of stay in hospital or inst. (yrs., mos., or days) 303 days
(e) Length of stay in Baltimore (yrs., mos., or days) 303 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County New York
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 South St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Balzer, Otto

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-7541

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1880

8. AGE: Years 65 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Cologne, Germany (Town, county, and state)

10. Usual Occupation mate

11. Industry or business seafarer

FATHER
12. Name Otto Balzer
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Schellsmidt
15. Birthplace Germany

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount Pennsylvania
Location York. R.D.

18 (a) Funeral director Oden Funeral Home Inc
(b) Address 1644 York Rd.

JAN 17 1946 (Date rec'd by Reg'r) (b) Registrar

Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1946, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17 1945, to Jan. 14 1946, and that I last saw him alive on Jan. 14 1946

Immediate cause of death #1-Perinephritic abscess right — Duration 2 weeks

#2-Adenocarcinoma of prostate

Due to with regional metastasis, cystitis and pyelonephritis — Duration UNKNOWN

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/24-6/6-7/22/45

Major findings of operation: Adenocarcinoma of prostate

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 1/16/46
US Marine Hospital, Balto, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36494

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dom.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1506 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) **FULL NAME:** Ernest Wilson

3 (b) If veteran, name war: ~
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1884

8. AGE: Years: 61 | Months: 3 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual Occupation: Laborer.
11. Industry or business:

FATHER
12. Name: Louis Wilson
13. Birthplace: Va.

MOTHER
14. Maiden Name: Sadie ?
15. Birthplace: Va.

16 (a) Informant: Ernest Wilson Jr.
(b) Address: 1506 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-17-46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location:

18 (a) Funeral director: Adolphus Hall Funeral
(b) Address: 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/12 19 46 at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: C. J. Sulzbach M.D.
Medical Examiner.
Date signed: 1/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G36495 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2367 Frederick Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME John Hoffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1945.

8. AGE: Years	Months	Days	If less than one day
—	1 1/2	13	— hr. — min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name John Hoffman
13. Birthplace Pa

MOTHER
14. Maiden Name Virgil Wilts
15. Birthplace Md.

16 (a) Informant Mother
(b) Address above

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Jan 18/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schyd.
(b) Address 505 N. Monroe St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams (Registrar)

JAN 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1946, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946, to 1/16 1946, and that I last saw h. alive on 1/16 1946.

Immediate cause of death Pneumonia

Due to Bronchus

Due to Dehydration

Other Conditions Cardiac

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sarah Cook M. D.
Address Univ. Hosp. Date signed 1/17/46

Sarah Cook X

(1-50) 150

G36496 BALTIMORE CITY HEALTH DEPARTMENT G36496 File No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — DO NOT WRITE IN SPACE RESERVED FOR BINDING.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Prince George's
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Pease

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Chas. Pease
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1886

8. AGE: Years	Months	Days	If less than one day
60	7	28	hr. min.

9. Birthplace West Virginia (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Snyder
13. Birthplace West Virginia

MOTHER
14. Maiden Name Elizabeth Rand
15. Birthplace West Virginia

16 (a) Informant Mrs. L. Mercer
(b) Address Oakcrest

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19 '46 (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Maryland

18 (a) Funeral director The W. C. [illegible]
(b) Address Laurel Md.

19 (a) (Date received by registrar) (b) Huntington Williams

JAN 17 1946
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1946 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension
Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratacap M.D.
Medical Examiner.
Date signed 1-17-46

X

636497 BALTIMORE CITY HEALTH DEPARTMENT 636497

CERTIFICATE OF DEATH 929

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 S. Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 S. Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARYA SMOKOWSKA

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): ? 1874
8. AGE: Years: 72 Months: Days: If less than one day: hr. min.
9. Birthplace: Gorlice, Poland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Stephen Haluch
13. Birthplace: Poland

MOTHER
14. Maiden Name: Apolonja Bialobok
15. Birthplace: Poland

16 (a) Informant: Mr. Casimir Smokowski
(b) Address: 233 S. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location: Mt. Carmel Road

18 (a) Funeral director: M. J. Sadowski & Son
(b) Address: 1808 Eastern Ave

19 (a) JAN 17 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1946, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Jan. 14 1946, and that I last saw her alive on Jan. 13 1946.

Immediate cause of death: Acute Cardio-Respiratory Decompensation — Duration: acute
Due to: Cardiac Asthma — ?
Due to: Chronic myocarditis — ?
Due to: Hypertension — ?
Other Conditions: Chronic Nephritis — ?

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Chas. Stemlos, M.D.
Address: 700 N. Patterson Park Ave. Date signed: 1/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G36498 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 S Paca St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S Paca St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Ahaus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-1878

8. AGE: Years 67 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Machinist Helper

11. Industry or business B & O R.R.

FATHER
12. Name Frederick Ahaus
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Schuman
15. Birthplace Baltimore Md

16 (a) Informant Miss Sophia Ahaus
(b) Address 805 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Randall & Humphreys
(b) Address 6067 Harford Rd.

19 (a) JAN 17 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15- 1946, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1946 to 1/15 1946, and that I last saw him alive on 1/15 1946

Immediate cause of death: Acute Cardiac Failure — Duration 1da

Due to: Cardio Vascular Renal

Due to: Disease — Duration Comp.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D. Lankatis M. D.

Address 679 Washington Blvd Date signed 1/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G36499

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 North Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Lee Hartley

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: William Mc K.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 7th 1897
8. AGE: Years 48 | Months 11 | Days 8 | If less than one day hr. min.
9. Birthplace Md.-
(Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business At Home
12. FATHER Name Geo. Grindle Sr
13. Birthplace Md.
14. MOTHER Maiden Name Linda Green
15. Birthplace Md.
16 (a) Informant Gerald S. Hartley
(b) Address 908 N. Charles St.
17 (a) Burial (b) Date thereof 1/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
19 (a) JAN 18 1946 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1946 at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13th 1946 to Jan 15th 1946, and that I last saw her alive on Jan 8th 1946

Immediate cause of death	Duration
Coronary occlusion	
Due to H C V D Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Smiley M. D.
Address Maryland General Hospital Date signed 1/16/46

VS 150

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G36500

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4903 Hamilton Ave
(c) Hospital or institution: Fair Side Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Northwood Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M Curran

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: ---

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1861

8. AGE: Years	Months	Days	If less than one day
84	7	17	hr. min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER — 12. Name Unknown Curran
13. Birthplace "

MOTHER — 14. Maiden Name "
15. Birthplace "

16 (a) Informant Frank T. Wallace
(b) Address 3019 Northwood Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co. Md

18 (a) Funeral director Wilson Lord Inc
(b) Address 1216 Park Ave

19 [illegible] (b) Huntington Williams, M.D. Registrar
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to 1/17 1946 and that I last saw h[illegible] alive on 1/16 1946

Immediate cause of death Hypertension
Cardio Vascular
Renal

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theo. Bolton M. D.
Address 5703 Harford Rd Date signed 1/17/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 636501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6808 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6808 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Strain Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Henry A. Jones

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 26 - 1859

8. AGE: Years 87 | Months 11 | Days 20 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm H. Strain
13. Birthplace Md.

MOTHER
14. Maiden Name Ann Mc Shaff
15. Birthplace Md

16 (a) Informant Mrs Johnston
(b) Address 6808 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director F. J. Phillpott & Son
(b) Address 300 Eutaw Place

19 (a) 1/18 1946 (b) Evelyn Williams Registrar
(Date received by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1946 at 5½ P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1935 to 1/15 1946 and that I last saw h[illegible] alive on 1/15 1946.

Immediate cause of death Coronary thrombosis

Due to following interfering factors Dilatation & Chronic Constipation (CONSTIPATION)

Duration 6-8 Yrs 8-10 Yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Cassell

Address 3912 Bradwell Date signed 1/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT BEGIN RESERVED FOR BINDING

636502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

Registered No. 636502

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Rose (Lottie Rosenzweig)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Not Known

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Austria

MOTHER
14. Maiden Name Emma
15. Birthplace Austria

16 (a) Informant Samuel Rosenzweig
(b) Address 2407 Eastern Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-18-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltor Conklin St

18 (a) Funeral director JACK LEWIS INC.
(b) Address 2100 EUTAW PLACE

JAN 18 1946 (Date received by Registrar) (b) Huntington Hilliquus Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15th 1946, at 10-11 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to Chronic Valvulitis (Rheumatic)

Other Conditions Acute pulmonary edema; Edema of brain; Hydro Thorax (bilateral), ascites
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelis M.D.
Medical Examiner.
Date signed 1-16-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G36503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 Brendan Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Brendan Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Ballman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1879

8. AGE: Years	Months	Days	If less than one day
66	5	27	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name John H. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Anna C. Kemmel
15. Birthplace Md.

16 (a) Informant Mr. John M. Ballman
(b) Address 3411 Brendan Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-18-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Rucker
(b) Address 5305 Harford Rd.

19 (a) (Delivered by registrar) (b) Huntingtown Williams, Md.

JAN 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1946 at 11:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1941 to Jan. 15 1946 and that I last saw her alive on Jan. 15 1946

Immediate cause of death Hypertensive C-V disease | Duration 12 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Stringer M. D.
Address 1402 B Lanvale St. Date signed 1-17-46

VS 150

G36504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 937

Registered No. G36504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 E. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFORD IRVING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910-9-9

8. AGE: Years	Months	Days	If less than one day
35	4	6	hr. min.

9. Birthplace Buckingham Co. Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Irving
13. Birthplace Va

MOTHER
14. Maiden Name Willie Chrustian
15. Birthplace Va.

16 (a) Informant Anna Chrustian
(b) Address 918 E. Spaulding Ave

17 (a) Burial (b) Date thereof Jan 20-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mullen Springs Va
Location Nelson County

18 (a) Funeral dir. Sam'l M. Chase Jr.
(b) Address 638 N. Belnor Ave

19 (a) JAN 18 1946 (b) Washington Williams Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/46 19 , at 1:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P. Weaver M.D.
Medical Examiner.
Date signed 1/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ORIGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G36505 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eutaw Place & Wilson St. Marlborough Apts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Marlborough Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME CARRIE B. FRANK.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis H. Frank.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1862.

8. AGE: Years	Months	Days	If less than one day
83	1	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Abraham Brafman,

13. Birthplace Germany.

MOTHER

14. Maiden Name Susan Weglein,

15. Birthplace Germany.

16 (a) Informant Mr. Henry L. Frank,

(b) Address 7 Slade Ave. Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/46. (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Balto. Md.

18 (a) Funeral director Burial Association of Am

(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) JAN 18 1946 (b) Registrar

VS 150

Hunting for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17th. 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945, to Jan. 17 1946, and that I last saw h.e alive on Jan 17 1946.

Immediate cause of death	Duration
Pneumonia. Cardiac Insuff	3 Days
Due to Sen. Hypertension & Art. Sclerosis	yrs
Due to Heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bernard Cohen M. D.

Address Marlborough Apts. Date signed

G36506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G36506 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 N. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Linda Carole Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/46

8. AGE: Years | Months | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Hardy

FATHER 12. Name William Tibbs McAdoo

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Ethel Marie Block

MOTHER 15. Birthplace Balto Md

16 (a) Informant Mother

(b) Address 804 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19th (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem Location Rural

18 (a) Funeral director Ulman Funeral Home

(b) Address 2008 Orleans St Williams for Huntington

19 (a) JAN 18 1946 (Date rec'd by registrar) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16, 1946, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Hydrocephalus	
Due to Spina Bifida	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Beaman M. D.

Address Sinai Hospital Date signed 1-17-46

VS 3

G36507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G36507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 840 George St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Pickett.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced D
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/2/12
8. AGE: Years 33 Months 2 Days 9 If less than one day hr. min.
9. Birthplace Blackstock, S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Ship Yard
FATHER 12. Name Jeff Pickett
13. Birthplace S.C.
MOTHER 14. Maiden Name Mary McCulloh
15. Birthplace S.C.
16 (a) Informant Jeff Pickett
(b) Address 1106 N. Carey St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory
Location Blackstock, S.C.
18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.
19 (a) 1-19-1946 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1946; at 8:02 P
21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1946, to 1-16 1946 and that I last saw h[illegible] alive on 1-16 1946

Immediate cause of death	Duration
Heart failure	
Due to Hypertensive Vascular Disease & Malignant type	
Due to Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dougla E. Buchanan M. D.
Address Univ. Hospital Date signed 1-17-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G36508
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2540 W Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 W Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: William L. Hughes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1890

8. AGE: Years 55 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Monroe Lam
13. Birthplace Va.

MOTHER
14. Maiden Name Mary L Cook
15. Birthplace Va.

16 (a) Informant William L. Hughes
(b) Address 2540 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Road

18 (a) Funeral director Harry A Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) JAN 18 1946 (b) Received by registrar Allington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 1/17 1946 and that I last saw h[illegible] alive on 1/16 1946.

Immediate cause of death

	Duration
Carcinoma of uterus	5 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma Biopsy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Reis M. D.
Address 2145 W Balto St Date signed 1/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Hennison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Hennison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August O. Abicht

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife: Ethel M. (Roby)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 29, 1895

8. AGE: Years 50 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Berlin, Md.
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business B. & O. R.R.

FATHER
12. Name Charles Abicht
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. Ethel M. Abicht
(b) Address 703 Hennison St.

17 (a) Burial (b) Date thereof Jan. 19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 E. Monument Ave

19 (a) JAN 19 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16, 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31/1945 to 1/16/1946, and that I last saw h— alive on 1/4/1946.

Immediate cause of death: Coronary Thrombosis — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Segum M. D.
Address 1 McEldnay Date signed 1/18/46

Samuel Segum

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36510

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Garrison Blvd. & Duvall Aves.
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15-8
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2607 Roslyn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: EDITH M. WILSON

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: J. Raymond Wilson
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 10, 1874

8. AGE: Years: 71 | Months: 11 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: James Isaac Bell
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Fannie Marshall
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Florence W. Glatzell
(b) Address: 2607 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/19/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 18 1946 (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH: Jan. 16, 1946 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1944 to 1-16 1946, and that I last saw h[illegible] alive on 1-16 1946

Immediate cause of death: Acut Congestive heart — Duration: 2dy
Due to: Pneumonia
Due to: Arterio Sclerotic heart
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Howard F. Warren M. D.
Address: 2004 Garrison Blvd Date signed 1-18-46

X

JL - 97575
G36511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G36511
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 - 10
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 513 S. Paca St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Kattie Helmers

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gerhard P. Helmers
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1865

8. AGE: Years: 81 | Months: — | Days: 14 | If less than one day: hr. min.

9. Birthplace: Md. Baltimore
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

FATHER
12. Name: William Smith Phonmatuel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Kattie ?
15. Birthplace: Germany

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18-1946 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Maryland

18 (a) Funeral director: Burger Funeral Home
(b) Address: 3221 Falls Road

19 (a) [illegible] (b) Walter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16 1946 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1945 to Jan. 16 1946 and that I last saw her alive on Jan. 16 1946.

Immediate cause of death: Cachexia, Duration
Due to: Carcinoma of left breast, mets to liver, mets to lungs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: James Jones
Address: Balto City Hosps Date signed: 1/16 M. D.

VS 150

G36512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1616

G36512 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Cedarhurst Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: PATRICIA PATTERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-45

8. AGE: Years | Months | Days 21 | If less than one day 20 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Harry Patterson
13. Birthplace Baltimore

MOTHER 14. Maiden Name Clarabelle Coster
15. Birthplace Baltimore

16 (a) Informant Harry Patterson
(b) Address 3200 Cedarhurst Rd

17 (a) Burial (b) Date thereof 1-19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Kendall E Humphreys
(b) Address 6067 Harford Rd

19 (a) Date received by Registrar JAN 18 1946
Registrar Huntington Williams, M.D.

US 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946, at 11:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Septicemia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Forster M.D.
Medical Examiner.
Date signed Jan 17 1946

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36513 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Belmont Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Belmont Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank T. Harcum

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lucy Harcum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1885

8. AGE: Years 60 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business

FATHER
12. Name Spencer Harcum
13. Birthplace Va

MOTHER
14. Maiden Name Amy Taylor
15. Birthplace Va

16 (a) Informant Raymond Harcum
(b) Address 1611 Belmont Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Wes. G. Kelson
(b) Address 1383 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 18 1946 Huntington Williams M.D.

VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 15 1946 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 11 1946 to Jany 15 1946 and that I last saw h[illegible] alive on Jany 14 1946

Immediate cause of death: Myocardial Failure — Duration: —

Due to: Influenza — Duration: 6 days

Due to: —

Other Conditions: Myocarditis (Chr) Arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Hoover M. D.

Address 601 N. Carrollton Ave Date signed 1/19/46

33B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G36514

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Elkins Home
(b) Street address 7101 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Appleby
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Daisy B. Appleby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1887

8. AGE: Years 58 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name William Appleby
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs. Violet Falice
(b) Address 1024 W. Lombard St

17 (a) Burial (b) Date thereof Jan (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 704 W. Lombard St

19 (a) (Date received by Registrar) JAN 23 1946 (b) Signature for Wilmer H. Hitt Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1945 to Jan 15 1946, and that I last saw him alive on Jan 14 1946

Immediate cause of death cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Patterman M. D.
Address 2324 Reisterstown Rd Date signed 1/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36515

BALTIMORE CITY HEALTH DEPARTMENT X 49a

CERTIFICATE OF DEATH

Registered G36515

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution:
Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nellie Myers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6. (b) Name of husband or wife Charles H. Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1893

8. AGE: Years	Months	Days	If less than one day
52	10	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Supt. Nurses
11. Industry or business Robb Wood Training School

FATHER
12. Name Roger McGill
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Kane
15. Birthplace Ireland

16 (a) Informant Mrs Editha Rubens
(b) Address 218 Church Lane, Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1946, at 9 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1946, to 1-16 1946, and that I last saw h[illegible] alive on 1-16 1946

Immediate cause of death	Duration
Pulmonary edema	
Due to Chron Hyp Dis	
Due to Metastatic Ca of brain	
Other Conditions Adeno Ca of mamma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Adeno Ca of mamma - met to brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George P. Callender M. D.
Address Univ Hosp Date signed 1-16-46

VS 150

X

G36516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 761 N. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 761 N. Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Janie Sewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Daniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1889

8. AGE: Years 56 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Queen Annes Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Isaac Johnson
13. Birthplace Queen Annes Co. Md.

MOTHER
14. Maiden Name Caroline Chambers
15. Birthplace Queen Annes Co. Md.

16 (a) Informant Mae Sawyer
(b) Address 824 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Chas. H. Holland
(b) Address 1631 Druid Hill Ave.
(c) Date filed by registrar JAN 18 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1946, at 5:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Jan 1946, and that I last saw h[illegible] alive on Jan 14 1946.

Immediate cause of death Chronic Myocarditis — Duration

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis L. Blake M. D.
Address 501 E. Eager St. Date signed 1/17/46

VS 150

G36517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36517 Registered No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 11/4/46
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Lawrence ST (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	3	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name	James Crinshaw
FATHER — 13. Birthplace	N. C.
MOTHER — 14. Maiden Name	unknown
MOTHER — 15. Birthplace	

16 (a) Informant James McKinnon

(b) Address 1513 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Wm. Jas. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) JAN 18 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 19 46 at 6P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Entrance 2nd - 3rd Degree Burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/2/46 at about 1 P M.
(b) Where did injury occur? 1510 Lawrence ST
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Burned by fire in above address house

23. Signature C. P. Dubuisson M.D. Medical Examiner.
Date signed 1/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

636518 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CHRISTIAN + ORMES
(c) Hospital or institution:
ST JOSEPHS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. Harford Rd & Hiss Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W Class

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Ida R Class
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/14/90

8. AGE: Years	Months	Days	If less than one day
55	1	4	hr. min.

9. Birthplace BALTO MD. (Town, county, and state)
10. Usual Occupation REAL ESTATE
11. Industry or business

FATHER
12. Name William Class
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dumer
15. Birthplace Germany

16 (a) Informant Edward Class
(b) Address Harford Rd & Hiss Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave E of Gay St

18 (a) Funeral director Leach Bros Funeral Home
(b) Address 7401 Belair Road

19 (a) (b) Registrar
(Date rec'd by registrar) JAN 18 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1946, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1946, to 1-17 1946, and that I last saw him alive on 1-11 1946

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	
Due to	
Other Conditions HYPERTROPHIC CIRRHOSIS	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy CARDIAC HYPERTROPHY PERIPHERAL RENAL SCLEROSIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Wells M. D.
Address 5 St Joseph Hosp Date signed 1-12-46

G36519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

G36519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Bowleys Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY ELLIGSON

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-07-9236

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M Elligson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 1879

8. AGE: Years 66 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace: Baltimore County (Town, county, and state)

10. Usual Occupation: Locker Hand

11. Industry or business: Continental Can Co

FATHER
12. Name: Julius Elligson
13. Birthplace: Germany

MOTHER
14. Maiden Name: Sarah E ----
15. Birthplace: Germany

16 (a) Informant: Mrs Henry Elligson
(b) Address: 1302 Bowleys Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road

18 (a) Funeral director: Lazarus Funeral Home
(b) Address: 7401 Belair Road

19 (a) [illegible] (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 JAN 1946. 12N

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Jan 1946. to 17 Jan 1946. and that I last saw h[illegible] alive on 17 Jan 1946.

	Duration
Immediate cause of death: Cardio-Respiratory Failure	
Due to: Hypertensive Cardio-Vascular Disease	
Due to: Arteriosclerosis generalized	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W Martin M. D.
Address St Joseph's Hospital Date signed 7 Jan 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

147B

Registered No. G36520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St.
(c) Hospital or institution: President Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mildred Sligh S33338

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	married

6 (b) Name of husband or wife James Sligh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-25

8. AGE: Years	Months	Days	If less than one day
20	4	–	hr. min.

9. Birthplace Union Bridge Md. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER 12. Name James Smith
13. Birthplace Union Bridge Md.

MOTHER 14. Maiden Name Mildred Smith
15. Birthplace Union Bridge Md.

16 (a) Informant James Sligh
(b) Address 1623 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1946 (Month) (Day) (Year)
(c) Cemetery or crematory Westminster Mem.
Location

18 (a) Funeral director Wm. Irvin R. Williams
(b) Address 3229 W. Belvedere Av.

19 (a) JAN 18 1946 (Date received by local registrar) Registrar.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15- 1946, at 10 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1946, to 1-15- 1946, and that I last saw h[illegible] alive on 1-15-1946.

Immediate cause of death Toxemia	Duration
Due to Toxemia	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan K. Bierer, M. D.
Address 601 N. Calhoun St. Date signed 1/17/46

Hunting for Delaware, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10 G36521 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1330 Cleveland St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Cleveland St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Rufus Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Dorothy Dorsey Williams
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Dec 19, 1909

8. AGE: Years	Months	Days	If less than one day
36	—	28	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Building Rigger.
11. Industry or business

FATHER
12. Name Redrand Williams
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katie Beardley
15. Birthplace Baltimore, Md.

16 (a) Informant Brother - Albert Williams
(b) Address 603 W. Conway.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) (Date rec'd by registrar) JAN 23 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1946, at 4:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Jan 1946 to 16 Jan 1946, and that I last saw h alive on Jan 16 1946.

Immediate cause of death Pneumonia, lobar, right Primary. — Duration 3 days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature John P. Ulrich, Jr. M.D.
Address 1222 Wash Blvd Date signed 17 Jan 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36522

HR #98460

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

Registered No. G36522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Helen Spears

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1920

8. AGE: Years	Months	Days	If less than one day
25	5	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Spears(d)
13. Birthplace ?

MOTHER
14. Maiden Name Mary Gant
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Kate P. Williams
(b) Address 322 N. Bakerouse St.

19 (a) JAN 18 1946 (b) Kate P. Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1946, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11, 1946 to Jan. 15, 1946 and that I last saw her alive on Jan. 15, 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert L. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 1/15/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G36523 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS JOHN McGUIN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 212-18-4929

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Lottie McGuin
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) June 18 1878

8. AGE: Years	Months	Days	If less than one day
67 71	6 7	8 27	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business 1750 Eastern Avenue

FATHER
12. Name John McGuin
13. Birthplace Penna

MOTHER
14. Maiden Name ? Groder
15. Birthplace Penna.

16 (a) Informant Mrs. Lottie McGuin - widow
(b) Address 1826 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by Registrar) (b) Registrar

JAN 18 1946 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1946, at 4.35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 m 1945 to Jan 14 1946 and that I last saw h ev alive on 1/14 46.

Immediate cause of death: Coronary thrombosis — Duration: 2

Due to: arteriosclerosis — Duration: 3 y.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A. M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. F. Faulkner M. D.
Address 1002 Hillen Date signed 1/18/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 134a

G36524 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. 245 Osborne Rd.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Helen B. Arthur

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband ~~or wife~~ Daniel B. Arthur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25. 1897

8. AGE: Years	Months	Days	If less than one day
48	0 1	21	hr. min.

9. Birthplace Aberdeen Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph Baldwin
13. Birthplace N.J.

MOTHER
14. Maiden Name Mary Farley
15. Birthplace N.J.

16 (a) Informant Mrs. Freddie Baldwin
(b) Address Aberdeen Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21-1946 (month) (day) (year)
(c) Cemetery or crematory Forest
Location Aberdeen Md

18 (a) Funeral director Henry Tanning Hood
(b) Address Aberdeen Md

19 (a) (b) Registrar

JAN 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1946, at 2 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1945, to Jan 18 1946, and that I last saw h-er alive on Jan 18 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Renal failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1/10/46
Major findings of operation: Renal calculi
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. Milton Linthicum
Address Mercy Hosp. Date signed 1/18/46 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G36525

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521- Brune St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 521- Brune St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Garnett over

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Elevator

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Al. Steele
(b) Address 521- Brune Stwt

17 (a) Burial (b) Date thereof 1-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 948- Penrod Alley

19 JAN 18 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1946 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1946 to Jan 17 1946 and that I last saw h alive on Jan 17 1946

Immediate cause of death Pulmonary TB

Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 75 [illegible] Date signed 1/17/46

VS 150

G36526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V

56 E

G36526 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution Balt 1, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie W. English

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Joseph English
6 (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) June 13 1903
8. AGE: Years 42 | Months 7 | Days 5 | If less than one day hr. min.
9. Birthplace Harford Co., Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Moses Walters
13. Birthplace Maryland
14. Maiden Name Ida Watters
15. Birthplace Maryland

16 (a) Informant Joseph English
(b) Address Bel Air R.D. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 1946 (month) (day) (year)
(c) Cemetery or crematory Rocks Cemetery
Location Rocks Md
18 (a) Funeral director Howard R. McComas Town
(b) Address Aberdeen Md
JAN 18 1946 (b) Washington Williams
(Date rec'd by local reg.) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29-45 19 to 1-17-1946. and that I last saw her alive on 1-17 19 46

Immediate cause of death: Pulmonary embolism — Duration

Due to: femoral thrombo-phlebitis

Due to: varices - post-op.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1-5-46, 1-14-46
Major findings of operation: varicose hematoma, Cl. Welchii
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm A. Holbrook Jr M.D.
Address Univ. Hosp. Date signed 1-19-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered G36527

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3412 Duvall Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Duvall Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Hynes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife May Ella Bump
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1868

8. AGE: Years	Months	Days	If less than one day
77	11	20 17	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John W. Hynes
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah E.
15. Birthplace Pa.

16 (a) Informant Mary Ella Hynes
(b) Address 3412 Duvall Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 18 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946; at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1945 to Jan. 17 1946, and that I last saw him alive on Jan. 17 1946.

	Duration
Immediate cause of death: Bronchial pneumonia	3 da
Due to: Myocarditis	7 mo.
Due to: Arteriosclerosis	?
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Trubb
Address 2220 Garrison Blvd. Date signed 1/18/46

VS 150

Dr. H. Boyd 24 E. Eager St Ba 3667

G36528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G36528 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hohkins Apartments
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Paul & Hohkins Apartments
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Welcke Gates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~ widowed, or ~~divorced~~
~~Female~~	White	Widowed

6 (b) Name of ~~husband or wife~~ Frank W. Gates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15th 1881

8. AGE: Years	Months	Days	If less than one day
64	1	2	hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation Clerical Work
11. Industry or business Red Cross

FATHER
12. Name Robert A. Welcke
13. Birthplace Bland

MOTHER
14. Maiden Name Ottilie Jurgens
15. Birthplace Germany

16 (a) Informant Olga Welcke Hawley
(b) Address 284 W. End Ave. - N. Y. City

17 (a) Cremation (b) Date thereof 1/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) Jan 18 1946 (b) Thomas Stanton Williams M.D.
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17th 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1946, to Jan 17 1946 and that I last saw ~~he~~ alive on Jan 16 1946

Immediate cause of death Myocardiac Carcinomatosis

Duration
6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Stanton Boyd M. D.
Address 24 E. Eager St Date signed 1/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G36529

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Poket St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 515 Poket St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mayo Lee Haggins Jr.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Male
5. Color or race Col
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 28 1929
8. AGE: Years 16 Months 6 Days 18 If less than one day hr. min.
9. Birthplace Baltimore Md. (city, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Mayo Lee Haggins Sr
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Voudelear Veale
15. Birthplace Baltimore Md.

16 (a) Informant Voudelear Haggins
(b) Address. 515 Poket St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19 46 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location

18 (a) Funeral director Robert L. Young
(b) Address 1340 N. Carolina St

JAN 18 1946

19 (a) Huntington Mills Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1946 at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-46 19 , to 1-16- 1946, and that I last saw h-- alive on 1-16-46 19 .

Immediate cause of death Myocardial Infarction — Duration 3 Hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 312 E 23rd N Date signed 1-17-46

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36530 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 S. Mason
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 S. Mason St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Garfield C. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-6761

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Mary E. Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24 1880

8. AGE: Years	Months	Days	If less than one day
65	11	20	hr. min.

9. Birthplace Gettysburg Pa (town, county, and state)

10. Usual Occupation Automobile Mechanic

11. Industry or business

FATHER
12. Name George Brooks
13. Birthplace Emmitsburg Pa.

MOTHER
14. Maiden Name Alice Eyler
15. Birthplace Emmitsburg Pa

16 (a) Informant Mary E. Brooks
(b) Address 415 S. Mason St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 19 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Eastern ave Road

18 (a) Funeral director Arendt & Heppel
(b) Address 315 S. Highland Ave

19 (a) Date received JAN 18 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946 at 10:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1945 to Jan 15 1946 and that I last saw h[illegible] alive on Dec 28 1945

Immediate cause of death

	Duration
(a) Myocarditis &	1 Yr 4 M
Coronary Disease Jan W	1 Yr 6 D
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Bleckman M. D.
Address 350 E Lafayette Date signed Jan 17/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36531 Fenzel

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G36531 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1455 Hull Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Fenzel

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8626

4. Sex male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Anne C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1884

8. AGE: Years 61 | Months 8 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Frank Fenzel
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Anna Fenzel
(b) Address 1455 Hull St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Hill.
(b) Address 1501 E. Fort Ave.

19 (a) JAN 18 1946 (Date rec'd by Registrar) Hunting for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1946 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5/ 1946, to 1/15/ 1946, and that I last saw h[illegible] alive on 1/15th 1946

Immediate cause of death Cardiac failure — Duration

Due to Left pneumonia and pulmonary edema

Due to

Other Conditions C. V. Disease & hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez M. D.
Address Maryland G. Hospital Date signed 1/16/46

over

X Gonzalez

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G36532 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 35 minutes

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Preston (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Spencer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1/12/46

8. AGE: Years	Months	Days	If less than one day
			35 minutes

9. Birthplace Mercy Hospital, Balto. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Virginia Spencer
15. Birthplace Va.

16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-46 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemet.
Location Balt.

18 (a) Funeral director J. A. Tully
(b) Address Fulton & Fayette Sts.

19 (a) JAN 18 1946 (Date rec'd by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1946 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1946, to 1/12 1946 and that I last saw him alive on 1/12 1946.

Immediate cause of death: Immaturity — Duration

Due to: Prematurity

Due to: Self-induced Abortion

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. K. Shelabey M. D.
Address Mercy Hosp. Date signed 1/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36533

BALTIMORE CITY HEALTH DEPARTMENT ✓ G36533

CERTIFICATE OF DEATH 132

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 Hunter St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 Hunter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lois Harris Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife Bowman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 21-1926

8. AGE: Years	Months	Days	If less than one day
19	9	25	hr. min.

9. Birthplace Penna
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name William Harris
13. Birthplace Idaho

MOTHER
14. Maiden Name Bertha Cromwell
15. Birthplace Md

16 (a) Informant Bertha Harris
(b) Address 2315 Hunter St

17 (a) Burial (b) Date thereof 1-19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

JAN 18 1946 (b)
(Date filed with Registrar) Registrar

VS 150

Huntington-Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 15 1946 and that I last saw h[er] alive on Jan 15 1946

Immediate cause of death
Pulmonary Tuberculosis — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. D. Jolleson M.D.
Address 2329 Guilford Ave Date signed 1-17 1946

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G36534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 Battery Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M. Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1869

8. AGE: Years 77 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Auzust Schwartz
13. Birthplace Germany

MOTHER 14. Maiden Name ?
15. Birthplace Germany

16. (a) Informant James A. Neal
(b) Address 1127 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-1946 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1420 Light St.

19 (a) (b) Date filed by registrar Huntington Williams M.D.

JAN 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/46 19 ; at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 45 to Jan 19 46 and that I last saw he alive on Jan 17 19 46

Immediate cause of death

Carcinoma of Urinary Bladder — Duration 1 mo

Due to

Due to

Other Conditions Acute Pancreatitis — 48 hours
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Muller M. D.
Address 1126 Cleveland St Date signed

X 1/17/46.

G36535

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G36535

CERTIFICATE OF DEATH 55E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2M 10D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [redacted] WESTMINISTER, MD. (b) County Carroll
(c) City or town WESTMINISTER (RURAL)
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. # 5 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ANNIE M. YOUNG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 3 1877 1868

8. AGE: Years	Months	Days	If less than one day
77	3	15	hr. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name FRANK WILLIAMS
13. Birthplace MAINE

MOTHER 14. Maiden Name SARAH UTZ
15. Birthplace PENNSYLVANIA

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory MEADOWBRANCH
Location WESTMINSTER MD.

18 (a) Funeral director J. F. Reese
(b) Address WESTMINSTER MD.

19 Date rec'd by JAN 19 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 18 1946, at 11:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 8 1945 to JAN 18 1946, and that I last saw HER alive on JAN 18 1946

Immediate cause of death INTESTINAL OBSTRUCTION — Duration

Due to CARCINOMA WITH METASTASIS POSSIBLY FROM K.U.B. TRACT

Due to

Other Conditions OCCLUSION OF ILIAC VESSELS BY TUMOR
(Include pregnancy within 3 months of death)

Date of operation 12-1-45

Major findings of operation: RETROPERITONEAL MASS; BIOPSY OF NODE SHOWED METASTATIC CA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee, III M.D.
Address Union Memorial Hospital Date signed 1/17/46

G36536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30a

Registered No. G36536

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State N J (b) County.....
(c) City or town Avon (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 MAIN (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** FREDRICK JAMES HINES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ELEANOR D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9 1898

8. AGE: Years 47 | Months 5 | Days 9 | If less than one day 8 hr. 20 min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation MINN.

11. Industry or business DRUG CLERK.

FATHER 12. Name JAMES HINES.
13. Birthplace EUROPE

MOTHER 14. Maiden Name MARY ?
15. Birthplace GERMANY

16 (a) Informant HOSP. RECORDS
(b) Address

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 1-19-46 (month) (day) (year)
(c) Cemetery or crematory ASBURY PARK
Location ASBURY PARK, N.J.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

JAN 19 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 18 1946, at 8:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 15 1946 to JAN 18 1946 and that I last saw h[illegible] alive on JAN 18 1946.

	Duration
Immediate cause of death CARDIAC FAILURE	
Due to RUPTURED BLADDER URINARY.	7
Due to LUES. (PRIMARY TABES DORSALIS	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-15-45
Major findings of operation: Carc. Urinary Bladder.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Ludwig J. Bystak M. D.
Address Union Memorial Date signed 1-18-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

636537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 636537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 21-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Woodward Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME WILLIAM W. SLOFFER

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NB

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Katherine H.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 1885

8. AGE: Years 60 | Months 1 | Days | If less than one day .....hr. .....min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Carpenter - Retired
11. Industry or business

FATHER
12. Name William H. Sloffer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Linder ?
15. Birthplace ?

16 (a) Informant Roland H. Saville
(b) Address 2650 W. Franklin St.

17 (a) Burial (b) Date thereof 1-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Wilhom Corkran
(b) Address 1217 St. Paul St.

JAN 19 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946, at 8:30PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 18 1946.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

636538

Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2 E 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 S. Wolfe st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Brokowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walenty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailoring

11. Industry or business

FATHER
12. Name Frank Skalski
13. Birthplace Poland.

MOTHER
14. Maiden Name ?
15. Birthplace Poland.

16 (a) Informant Albert Kosky
(b) Address 604 S. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

JAN 19 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1946, at 8 20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Crushed chest.

Due to

Other Conditions Fracture rt. humerus, Contusions of back.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/17/46 at 2/1 8:04 P.M.
(b) Where did injury occur? Wolfe st & Pratt st
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Collision of auto & tractor-trailer

23. Signature Benedict Skiterales M.D. Medical Examiner.
Date signed 1-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G36539 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Lancaster St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Lancaster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Krol

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sophie Krol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1879

8. AGE: Years 66 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Self

FATHER
12. Name Pete Krol
13. Birthplace Poland

MOTHER
14. Maiden Name York.
15. Birthplace Poland

16 (a) Informant Helen Janowski
(b) Address 1716 Lancaster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave

19 (a) (Date rec'd by registrar) JAN 19 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1946, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 17 1946 and that I last saw him alive on Jan 17 1946

Immediate cause of death: Hypostatic Pneumonia — Duration 1/14/46

Due to Chr. Myocard. Dis — 3/1944

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Roarer M. D.
Address 801 N. Rendon Rd Date signed 1/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36540

486733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G36540 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claudio Macciola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-23-83

8. AGE: Years	Months	Days	If less than one day
63	11	25	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Vincenzo Macciola
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Corvinelli
15. Birthplace Italy

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Delair, N.J. Mount View Ave

18 (a) Funeral director Frank Della Vora
(b) Address 52 N. Morley St.

19 (a) JAN 19 1946 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1946 at 12 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1946 to Jan. 17 1946, and that I last saw him alive on Jan. 17 1946.

Immediate cause of death	Duration
Generalized Cachexia	3 mos
Due to Carcinoma of bladder	1½ yrs
Due to 8/13/45,	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8/13/45, 9/1/45
Major findings of operation: Extensive Carcinoma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan L. Lewis, M.D.
Address Johns Hopkins Hosp. Date signed 1/17

VS 150

G36541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G36541 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutow Place
(c) Hospital or institution:

5-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 247 East St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonina T. Torre

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband ~~of wife~~ Domenick Torre
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 22 1892

8. AGE: Years	Months	Days	If less than one day
53	1	26	hr. min.

9. Birthplace Bafia Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Domenico Triola
13. Birthplace Italy

MOTHER
14. Maiden Name Venera Sofia
15. Birthplace Italy

16 (a) Informant Domenick Torre (Husband)
(b) Address 247 East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Marley St.

19 (a) (Date rec'd by registrar) (b) Huntington Hill Registrar

VS 150 JAN 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18-46, 1946, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1945 to 1-16-46 1946, and that I last saw her alive on 1-16 1946.

Immediate cause of death: Cerebral hemorrhage — Duration
Due to: arteriosclerosis cerebri
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold H. Bix M. D.
Address 2516 Linden Ave Date signed 1-18-46

X

G36542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G36542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered; if not known, supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: University Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 1321 N. Carey St (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruby crawford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife Comet W Crawford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 - 1912

8. AGE: Years	Months	Days	If less than one day
34	-	15	hr. min.

9. Birthplace Lancaster Co Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Yerby
15. Birthplace Merry Point Va

16 (a) Informant Comet Crawford
(b) Address 1321 N. Carey St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan 20/46 (month) (day) (year)
(c) Cemetery or crematory Church Cemetery
Location Merry Point Va

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) JAN 19 1946 (Date rec'd by registrar) (b) Livingston Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to 1-16 1946 and that I last saw her alive on 1-16 1946

Immediate cause of death Pulmonary embolism — Duration

Due to phlebothrombosis

Due to

Other Conditions Grade IV ca of cervix
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Cam M. D.
Address University Hospitals M. D.

G36543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36543 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hemphill Ave
(c) Hospital or institution:
Pineridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Northway Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Quirk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Agnes H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1869

8. AGE: Years	Months	Days	If less than one day
76	2	3	hr. min.

9. Birthplace Havre de Grace Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Dennis Quirk
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Hallahan
15. Birthplace Ireland

16 (a) Informant Mrs. Irvin Homburg
(b) Address 3116 Northway Drive

17 (a) Burial (b) Date thereof Jan 21 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Airey
Location Havre de Grace

18 (a) Funeral director L. J. Ryck
(b) Address 5305 Harford Rd

19 (a) JAN 19 1946 (b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1946 to 1/18 1946 and that I last saw him alive on 1/18 1946

Immediate cause of death Hypertensive Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kyle M. Golley
Address 570 E Hartford Rd Date signed 1/20/46

Kyle M. Golley

VS 150

G36544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G36544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Fleetwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Fleetwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Irene J. Bau-

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry R.

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 20 - 1881

8. AGE: Years	Months	Days	If less than one day
64	2	29	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James Oswald
13. Birthplace Balto Md

MOTHER
14. Maiden Name — Johnson
15. Birthplace Balto Md.

16 (a) Informant Mr Henry R. Bau-
(b) Address 2702 Fleetwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director L. J. Rulk
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 19 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1946 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1946 to 1/18 1946 and that I last saw her alive on 1/18 1946.

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leland Bailey

Address 5703 Harford Rd signed 1/18/46

X

636545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

636545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution:
Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County do
(c) City or town Gambrills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edward Lee Cheney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	co	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 - 1896

8. AGE: Years	Months	Days	If less than one day
49	4	13	hr. min.

9. Birthplace Gambrills Md
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Alfred Cheney
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Penn
15. Birthplace Maryland

16 (a) Informant Nicholas Cheney
(b) Address Gambrills. Md

17 (a) Burial (b) Date thereof Jan 21 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Memorial
Location Millersville. Md

18 (a) Funeral director B. L. Hopkins
(b) Address Annapolis. Md.

19 (a) JAN 19 1946 (b) Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1:0 PM Jan 19 1946, to 5:40 PM Jan 19 1946, and that I last saw him alive on Jan 14 1946.

Immediate cause of death	Duration
Respiratory collapse	
Due to Lobar Pneumonia & consolidation of right lung	1 wk.
Due to	
Other Conditions Auricular fibrillation (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. L. Strickel Jr. M. D.
Address Bon Secours Hosp. Date signed 1/19/46

G36546
485873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36546 Registered No. 1233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgia Wilson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-89

8. AGE: Years	Months	Days	If less than one day
56	11	29	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Julian Shelton
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Booker
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory Wilson Family Plot
Location Dunkirk Va.

18 (a) Funeral director Edward W. Sulkowski
(b) Address 117 N. Carrollton Ave

19 (a) JAN 19 1946 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan-18 1946 at 12.05 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec-29 1945 to Jan-18 1946, and that I last saw her alive on Jan 18 1946.

Immediate cause of death	Duration
Cardiac failure	
Uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-9-46
Major findings of operation: Hydronephrosis bilateral Hydroureter, bilateral
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Russell Jordan
Address 600 N Broadway Date signed 1/18/46

VS 150 Huntington Williams, M.D.

G36547

BALTIMORE CITY HEALTH DEPARTMENT

TM. 98554

CERTIFICATE OF DEATH

832

G36547
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Newton

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22nd 1859

8. AGE: Years	Months	Days	If less than one day
86	8	24 26	hr. min.

9. Birthplace Vermont
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Albert Newton
13. Birthplace Vermont

MOTHER
14. Maiden Name Carrie Niles
15. Birthplace Vermont

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 1/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 JAN 19 1946 by [illegible] for William H. Taylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18th 1946, at 1.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14th 1946, to Jan. 18 1946 and that I last saw him alive on Jan. 18 1946.

Immediate cause of death	Duration
Cerebral thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not available

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jonathan Howland M. D.
Address A C H Date signed 1/18/46

VS 150

Spec.—U 30—A. & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE G36548

G36548

CERTIFICATE OF DEATH. 83a

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Washington St. Ward 5)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Joseph Fogerty

(a) RESIDENCE NO. 817 N. Washington St-5 ST., 7-5 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 2 mos 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances Aloysia Fogerty

6 DATE OF BIRTH (month, day, and year) 12 Nov 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stock clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Printing
(c) Name of employer Lord Balto Press

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS
10 NAME OF FATHER James Fogerty
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Nora O'Gorman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frances A. Fogerty
(Address) 817 N Washington St

15 Filed ....., 19 ..... Registrar

JAN 19 1946

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 18 1946

17
I HEREBY CERTIFY, That I attended deceased from 6 Jan, 1946, to 18 Jan 1946
that I last saw h.. alive on 18 Jan 1946
and that death occurred, on the date stated above, at 5-55 P m.

The CAUSE OF DEATH* was as follows:
Hypertension con

(duration) 18 yrs. mos. ds.
CONTRIBUTORY (Secondary) Apoplectic Stroke
(duration) yrs. mos. 7 days

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J Hulla M.D.
18 Jan 46, 19 (Address) 9214 Fayette St-31

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL Jany 22 1946

20 UNDERTAKER Harry H Annacost — ADDRESS 4204 Edmondson Ave

TION is very important. See instructions on back of

636549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1936

636549
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 N Bruce ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY AGATE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Josephine Agate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1875

8. AGE: Years	Months	Days	If less than one day
70 71	4	1	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Cabinet maker
11. Industry or business Amnesia Fixture Co

FATHER
12. Name Michael Agate
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Donna
15. Birthplace Italy

16 (a) Informant Wife Josephine Agate
(b) Address 403 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V Depiro
(b) Address 245 E Baltimore St

19 (a) JAN 19 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1946 at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1946 to Jan 16 1946 and that I last saw him alive on Jan 16 1946

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertensive Cardio Vascular Disease	
Other Conditions Arteriosclerosis generalized	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Laurence A Martin M. D.
Address St Josephs Hosp Date signed 16 Jan 1946

VS 150

G36550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G36550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2926 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ambrose J. Lengner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 714-05-6651

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Married

6 (b) Name of husband or wife Julia R. Lengner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1891

8. AGE: Years	Months	Days	If less than one day
54	8	0	hr. min.

9. Birthplace Baltimore (Town, county, and State)
10. Usual Occupation Driver of truck
11. Industry or business Railway Express Agency

FATHER
12. Name George J. Lengner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Agnes Owings
15. Birthplace Baltimore

16 (a) Informant Mrs Clara M. Reiter
(b) Address 1511 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.V. Co. Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1422 Light St.

19 (a) (Date received by registrar) (b) Huntington Williams, M. D.

JAN 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17, 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1946, to 1/17 1946, and that I last saw h[illegible] alive on 1/15 1946.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerotic Cardio-	?
Due to Vascular Disease	
Other Conditions Chronic Nephritis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D. Bloom M.D.
Address 120 E. Preston St. Date signed 1/19/46

G36551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G36551
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 W. Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin H. Banks

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Cynthia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1889

8. AGE: Years 56 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Nash, D.C. (town, county and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name George H. Banks
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Annie Hardy
15. Birthplace Alabama

16 (a) Informant Ruth Fulton
(b) Address 1725 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lucy A. Holland
(b) Address 1631 Druid Hill Ave
(c) Baltimore, Md.

JAN 19 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-1946, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1946, to 1-11 1946, and that I last saw h[illegible] alive on 1-11-1946

Immediate cause of death	Duration
Coronary Occlusion	
Due to Cerebral Hemorrhage	
Due to Hypertensive C-V Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Jenny M. D.
Address Univ. Hosp. Date signed 1-16-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G36552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G36552

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 Chauncy Rd.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltotcity
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Chauncy Rd (If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country —

3 (a) FULL NAME Jacob Frederick Shafer

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anetta M. Shafer
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 25-1880

8. AGE: Years 65 | Months 1 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Food Broker
11. Industry or business (self)

FATHER
12. Name Jacob C. Shafer
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah R. Horn
15. Birthplace Baltimore Md.

16 (a) Informant Charles C. Shafer (Son)
(b) Address 1547 Hanover Rd (Md)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart-Mowell Co.
(b) Address 1084 W North Ave.

19 (a) Received JAN 19 1946 (b) Registered JAN 19 1946 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18- 1946, at 12 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12- 1946 to 1-18- 1946 and that I last saw h— alive on 1-18-1946.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Waitman T. Zirkin M. D.
Address Medical Arts Bldg Date signed 1-19-46

Waitman Zirkin X

G36553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G36553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 Westgate Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Westgate Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John Milton Frizzell

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cora Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 28, 1888

8. AGE: Years 57 | Months | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Mfgt Agent

11. Industry or business

FATHER
12. Name Geo. Frizzell
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Emma Dennis
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Cora V. Frizell
(b) Address 500 Westgate Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

JAN 20 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15// 19 46, at 1:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Jan 15 1946, and that I last saw h/ alive on Jan 15 1946.

Immediate cause of death	Duration
Chr. Myocarditis.	
Due to	
Due to	
Other Conditions Cardiac Asthma.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 520 Med. Arts Bldg. Date signed 1/16/46

VS 150

G36554 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G36554

CERTIFICATE OF DEATH 932

Registered No.

Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT IN INDELIBLE PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maternity Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Patapsco Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eli Burley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Effie Burley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	8	hr. min.

9. Birthplace A. A. Co. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Coal Company

FATHER
12. Name Ezekiel Burley
13. Birthplace A. A. Co. Md

MOTHER
14. Maiden Name Henrietta ?
15. Birthplace A. A. Co. Md

16 (a) Informant Effie Burley
(b) Address Patapsco Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Deale & Brewington
(b) Address 102 W Montgomery St

19 (a) 1946 (Date rec'd by registrar) (b) Register

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/46 19 , at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic & Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Pairo, M.D.
Medical Examiner.
Date signed 1/15/46

VS 151

AB-98466 G36555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

✓ G36555 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15- 1899

8. AGE: Years	Months	Days	If less than one day
46	5 4	2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Georgianna Egans
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A.A.Co Md

18 (a) Funeral director Isaiah C Brown Son
(b) Address 1054 Montgomery St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 20 1946

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Jan. 17 1946 at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1946 to 1-17- 1946 and that I last saw h im alive on 1-17- 1946

Immediate cause of death Uraemia

Due to Uraemia, urinary Retention and infection

Due to

Other Conditions Prostatic cyst, ureters, urethral Stricture (Chronic)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J Mc Ca
Address Bon Secours Hosp Date signed 1/18/46

VS 150

G36556 BALTIMORE CITY HEALTH DEPARTMENT G36556
Registered No.

CERTIFICATE OF DEATH 181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1019 Carlton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Waters, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-19-1868
8. AGE: Years 77 | Months 11 10 | Days 2 28 | If less than one day hr. min.
9. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business none
FATHER 12. Name John Waters Sr.
13. Birthplace Md
MOTHER 14. Maiden Name Rosie Moore
15. Birthplace Md
16 (a) Informant Patient
(b) Address
17 (a) Burial (b) Date thereof 1-19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blanchard Ave
19 (a) JAN 20 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1946, at 4 45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1945 to 1-17 1946; and that I last saw h. alive on 1-17 1946.

	Duration
Immediate cause of death Uremia	
Due to Acute nephritis	
Due to Burns about body	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-24-45 at 9 15 P M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Burned while sleeping near stove
23. Signature J J Corbett M. D.
Address 1574 Division St Date signed 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Honora J. Uncini, M. D. X

G36557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G36557

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:
Ventura Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Park Apts.
100 Upland Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA D. LADD

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6. (b) Name of husband or wife H. F. Ladd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1861

8. AGE: Years	Months	Days	If less than one day
84	9	24	hr. min.

9. Birthplace Atwater, Ohio
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Cavinder
13. Birthplace Ohio

MOTHER
14. Maiden Name Harriet Sears
15. Birthplace Randolf, Ohio

16 (a) Informant Mr. H. F. Ladd
(b) Address Roland Park Apts.

17 (a) Removal (b) Date thereof Jan. 19, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Ravenna, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 20 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Jan. 18 1946 and that I last saw her alive on Jan 18 1946

Immediate cause of death Cardio Respiratory Failure — Duration

Due to Hypostatic Pneumonia

Due to Arteriosclerotic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howland Edmund Day M.D.
M. D.
Address 4-E-33rd St Date signed Jan 19 1946

VS 150

G36558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

G36558 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1330 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George L. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1863

8. AGE: Years 82 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Matthews Co. Va (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Henry Cook
13. Birthplace Matthew Co. Va

MOTHER 14. Maiden Name Susan Cook
15. Birthplace Matthew Co. Va

16 (a) Informant Mrs. Estelle Morgan
(b) Address 1330 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Hyland
(b) Address 1631 Druid Park Ave.

19 (a) (Date received by registrar) (b) Registrar

JAN 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1946, at 5 35 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1946 to 1-18- 1946, and that I last saw h[illegible] alive on 1-18- 1946.

Immediate cause of death: Bronchopneumonia — Duration: 1 wk.
Due to: Cardiac Vascular Renal
Due to:
Other Conditions: Arteriosclerosis

(Include pregnancy, within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dorman Higgins M. D.
Address 2243 Madison Date signed 1/19/46

G36559 ✓ G36559

G36559 BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Koop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Morris Koop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Manuel -
13. Birthplace Poland

MOTHER 14. Maiden Name Leah -
15. Birthplace Poland

16 (a) Informant Morris Koop
(b) Address 710 Frederick Ave, Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-46 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Rd
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E. Balto St

19 (a) 1-18-1946 (b) Huntington Williams, MD
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1946, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1945 to 1/15 1946, and that I last saw her alive on 1/15 1946.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerotic Cardiovascular renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Bloom MD

Address 120 E Preston St Date signed 1/15/46

X

636560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 Windsor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Windsor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Rosenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Rose Wasserman
(b) Address 2325 Windsor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-46 (month) (day) (year)
(c) Cemetery or crematory Pradale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1424 E. Balto St

19 (a) (Date filed by registrar) (b) Registrar

20 1946

(Huntington Williams, M.D.)

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Jan 18 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from [redacted] 19 to Jan 18 1946, and that I last saw h alive on Jan 18 1946

Immediate cause of death	Duration
Uremia	
Cardiac hypertrophy	1 mo
Due to Arteriosclerosis	
Due to Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Steindler M. D.

Address 7314 W. North Ave Date signed 1/19/46

VS 180

G36561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

G36561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 PENNA AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THERESA ~~MANEKIN~~ MANEKIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife MORRIS B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1846

8. AGE: Years	Months	Days	If less than one day
100			hr. min.

9. Birthplace BALTO. MD
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name ABRAHAM MILLER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name EVA
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (b) Date thereof 1-20-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO + CONKLIN ST

18 (a) Funeral director Jack Sens Inc
(b) Address 1439 E. Balto. St

19 (a) 1-20 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1946, at 1155 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1945 to 1-18 1946 and that I last saw h alive on 1-18 1946.

Immediate cause of death Carcinomatosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley Ray Steinbach M. D.
Address Sinai Hospital Date signed 1-19-46

VS 150

G36562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G36562 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 Brookfield ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 3mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Halpern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Dawid C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Abraham Hoffman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Dorothy H Dorf
(b) Address 2419 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-46 (month) (day) (year)
(c) Cemetery or crematory Har Nebo
Location

18 (a) Funeral director Jack Pevsner Inc
(b) Address 1439 E. Baltimore

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17-1946 at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Jany 17 1946, and that I last saw h[illegible] alive on Jany 17 1946.

	Duration
Immediate cause of death: Carcinomatosis since	Nov 1945
Due to: Carcinoma Ileum (Hepatic Flexure)	
Due to: Hysterectomy	Dec 1945
Other Conditions: (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P Hamburger M. D.
Address 1207 Eutaw Pl Date signed 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G36563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G36563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 E. Chase Street
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 68 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. Chase Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles E. Wenzel (Engelbert Wenzel)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barbara Arnreich

6 (c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.) Nov. 5th 1862

8. AGE: Years	Months	Days	If less than one day
83	2	14	###### min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Carpenter, Own Business

FATHER
12. Name: Englebert Wenzel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Barbara Wenzel
(b) Address: 1620 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belaire Road Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

1946

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946, to 1/15 1946, and that I last saw h[illegible] alive on 1/18 1946

Immediate cause of death: Pneumonia
Hypostatic of Pneumonia
Senility

Duration: 3

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Del Smith M. D.

Address 1223 E. North Ave Date signed 1/15/46.

X

G36564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1237 E. Eager Street
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1237 E. Eager Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J. Fell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Aloysius B. Fell
6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Aug. 21, 1890

8. AGE: Years	Months	Days	If less than one day
55	4	27	######## min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Nicholas W. Scheel
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary B. Hamper
15. Birthplace: Baltimore, Md.

16 (a) Informant: Aloysius B. Fell
(b) Address: 1237 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto; Md.

JAN 20 1946

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) JAN 20 1946 (Date rec'd by registrar) by for Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1946 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Jan. 17 1946 and that I last saw her alive on Jan. 17 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 hrs.
Due to: Malignant Hypertension — Duration: 1 year
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature W. H. Stranger M.D.
Address 402 E. Lanvale Date signed 1-18-46

VS 150

G36565 BALTIMORE CITY HEALTH DEPARTMENT G36565

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 N. Luzerne Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Luzerne Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore A. Lanzilla

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1869

8. AGE: Years 76 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Charles Lanzilla

13. Birthplace Australia

MOTHER 14. Maiden Name Macko

15. Birthplace Australia

16 (a) Informant Margaret

(b) Address 132 N. Luzerne Av

17 (a) Burial (b) Date thereof 1/21/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Baltimore Md.

18 (a) Funeral director Thos. A. McMann

(b) Address 3600 E. Balto. St

19 (a) 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1946, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Jan 17 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	1/15/46
Due to Chr Myocarditis	10/1/45
Due to arterio Sclerosis	1941
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Roarer M. D.

Address 801 N. Kenwood Ave Date signed 1/18/46

VS 150

636566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

636566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Praley

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Edward Praley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1876

8. AGE: Years	Months	Days	If less than one day
69 70	5	27	hr. min.

9. Birthplace Europe (town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name H. Bassel
13. Birthplace Europe

MOTHER
14. Maiden Name Anna Rohman
15. Birthplace Europe

16 (a) Informant Edward L. Praley.
(b) Address 138 N. Streper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director E. Walter Mayr.
(b) Address 619 N. Boulevard St

19 (a) (Date rec'd by registrar) (b) Lingan Williams, Registrar

JAN 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1946 at 6.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Jan 18 1946, and that I last saw her alive on Jan 18 1946.

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to Hypertension - C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Wheeler M.D.
Address South Balto. Gen. Hosp. Date signed 1-18-46

G36567 BALTIMORE CITY HEALTH DEPARTMENT X G36567

CERTIFICATE OF DEATH ✓186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Aves
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Clarksville (If outside city or town limits, write RURAL and give town)
(d) Street No. Cedar Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W Day
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Helper
11. Industry or business

FATHER
12. Name Harry Day
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Bakers
15. Birthplace Md

16 (a) Informant Leonard Day
(b) Address Clarksville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Highland Md.

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

19 (a) 1946 (Date received by registrar) (b) Walter Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1946, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1945, to 1/19 1946, and that I last saw h[illegible] alive on 1/19 1946.

Immediate cause of death: Pulmonary embolism
Due to
Due to
Other Conditions Non-[illegible]
pregnancy 4 weeks
(Including pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence December 29 1945 M
(c) Where did injury occur? Clarksville Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? in house
(e) Means of injury Fall & hit floor

23. Signature Jos O'Leary & Chandler M. D.
Address St Agnes Hosp Date signed 1/19/46

For S. J. Lubowski, by Howard J. Mathieu, M. D.

G36568 BALTIMORE CITY HEALTH DEPARTMENT X G36568

CERTIFICATE OF DEATH ✓ 94a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Nancy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 3rd Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Reithmueller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude R.

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) July 13, 1899

8. AGE: Years 46 | Months 6 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Heat & Power Co.

FATHER 12. Name Henry Reithmueller

13. Birthplace Wash. D.C.

MOTHER 14. Maiden Name Sarah Devilliss

15. Birthplace Maryland

16 (a) Informant Mrs. Gertrude Reithmueller

(b) Address 308 Third ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21, 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Balto. County

18 (a) Funeral director Frederick H. Cole

(b) Address 1700 W. Lombard St.

19 (a) JAN 20 1946 (Date received by Registrar) (b) Burial Permit No.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1946, at 8:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res. death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

If external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.

Date signed 1-18-46

G36569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36569 Registered No.

1-70C

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH INDELIBLE INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Elm Ridge Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bruce Meeth

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Bernardine M.
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) June 21, 1909

8. AGE: Years	Months	Days	If less than one day
36	6	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business

FATHER
12. Name Harry Meeth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Wilhelmina Kistler
15. Birthplace Baltimore

16 (a) Informant Mrs Bernardine Meeth
(b) Address 1205 Elm Ridge Rd Catonsville

17 (a) Burial (b) Date thereof Jan. 22 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1700 W. Lombard St.

19 (a) JAN 20 1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1946, at 2 30 M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 17, 1946
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? public hiw While at work? No
(d) Means of injury auto ran into tree

23. Signature Robert Lee Fretwell M.D.
Medical Examiner.
Date signed Jan 19 1946

G36570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

482

G36570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. CLARA BELLE YEARLEY

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Henry W. Yearley
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1884

8. AGE: Years	Months	Days	If less than one day
61	11	10	hr. min.

9. Birthplace Massachusetts
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Alfred Keeler
13. Birthplace Michigan

MOTHER
14. Maiden Name Georgiana Cook
15. Birthplace Massachusetts

16 (a) Informant Henry W. Yearley
(b) Address 2022 N Calvert St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 1/20 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Bridge
Location Huntington Mass

18 (a) Funeral director Fulton & Dove
(b) Address 1219 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar
JAN 21 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946 at 9.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1945 to 1/19 1946 and that I last saw her alive on 1/19 1946

Immediate cause of death: Coronary

Due to: Bilateral hydrothorax

Due to: Extensive Coronary Sclerosis

Other Conditions: Arteriosclerotic Heart Disease

(Include pregnancy within 3 months of death)

Date of operation 1/18/46

Major findings of operation: Cor. Sclerosis

of autopsy:

Duration
2 wks.
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest M. Fenner M. D.
Address Church Home & Hosp. Date signed 1/19/46

X

G36571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460

Registered No. G36571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegh-
(c) City or town Lonaconing
(If outside city or town limits, write RURAL and give town)
(d) Street No. Big Vein Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tivan Humphrey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Pheobe Humphrey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-13-76

8. AGE: Years	Months	Days	If less than one day
69	10	7	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Miner on OAP.

FATHER
12. Name John Humphrey
13. Birthplace England

MOTHER
14. Maiden Name Isabel Clauson
15. Birthplace Scotland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Lonaconing Md.

18 (a) Funeral director Wm. J. Tichnor & Son
(b) Address No. 7 Penna. ave. Balto Md.

19 (a) JAN 21 1946 (b)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1946 at 11 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1945 to 1-20 1946 and that I last saw h.. alive on 1-2 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to General debility	
Due to Penicillamitis due to gastrostomy 19 Jan 45	2 days
Other Conditions Carcinoma of esophagus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: inoperable Carcinoma of esophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

I Signature William E. Grove
Address Johns Hopkins Hospital
Date signed 20 Jan. M. P. 45

VS 150

X Dr. Graves

G36572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Roland Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Roland Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Ellen Carroll

3 (b) If veteran, name war V

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Thomas Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23-1861

8. AGE: Years	Months	Days	If less than one day hr.	min.
84	1	28		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name John T. Wilkinson
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Ellen Lambert
15. Birthplace Md

16 (a) Informant Mrs Bryan
(b) Address Stevensville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-46 (month) (day) (year)
(c) Cemetery or crematory Stevensville
Location Stevensville Md

18 (a) Funeral director Edgar D. Lane
(b) Address Church Hill Md

19 (a) (Date rec'd by reg'strar) (b) Registrar

JAN 21 1946

Waiting for Will

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1946 at 1 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1946 to Jan 20 1946 and that I last saw her alive on Jan 20 1946.

Immediate cause of death Pulmonary edema — Duration 1 WK.
Due to Myocardial Insufficiency
Due to
Other conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Lamphier M.D.
Address 307 E. 33rd St Date signed 1/20/46

VS 150

G36573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3432 Lyndale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 Lyndale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Victoria Silkinton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife Philmore J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 11 - 1867

8. AGE: Years	Months	Days	If less than one day
78	10	6	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William H Keeler
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Ann
15. Birthplace Md.

16 (a) Informant Mrs. Charles Kinney
(b) Address 3432 Lyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 530 Harford Rd.

19 JAN 21 1946 (Date rec'd by Registrar) Hunter for Williams (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 - 1946, at 3:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1940, to 1-17- 1946, and that I last saw her alive on 1-17- 1946.

Immediate cause of death	Duration
Carcinoma of Left Breast	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton D. Laug M. D.
Address 217 Belair Rd Date signed 1-19-46

VS 150

G36574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G36574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2521 Arquell St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Arquell St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles Frederick Schuetz

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-01-3373

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillie M Schuetz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1890

8. AGE: Years	Months	Days	If less than one day
55	10	25	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Lord Baltimore Press

FATHER
12. Name Frederick C Schuetz
13. Birthplace Germany

MOTHER
14. Maiden Name Melonia Caroline Rogers.
15. Birthplace Baltimore Md

16 (a) Informant Mrs Lillie M Schuetz
(b) Address 2521 Arquell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director L J Burke
(b) Address 5316 Harford Rd

19 (a) JAN 21 1946 (Date rec'd by registrar) (b) Huntington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946, at 12 20a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1946, to June 19 1946, and that I last saw h alive on June 18 1946.

	Duration
Immediate cause of death Coronary Thrombosis	3 Hrs.
Due to Arteriosclerosis	3d
Due to Hypertension	3d
Due to Chronic Interstitial Nephritis	3d
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Ca Stevens M. D.
Address 2878 Harford Rd Date signed 1-19 46

correct age is especially important. Physicians: please write the

G36575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County.....
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 154 North Eutaw
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME GERTRUDE BETHEA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife E. J. Bethea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1882

8. AGE: Years 63 64 | Months 4 | Days 27 | If less than one day ....hr. ....min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Henry Watson
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Rachel Watson
15. Birthplace Annapolis, Md.

16 (a) Informant Helen I. Wagner
(b) Address 1004 N. Payson St

17 (a) 1/21 (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Brooklyn

18 (a) Funeral director Chas. Alexander
(b) Address 1200 McCulloh St

19 (a) Date received by Local Registrar for Wills 1946 (b) JAN 21 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13/46 19.... at 7:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Otho R. Davis M.D.
Medical Examiner.
Date signed 1/14/46

X

G36576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G36576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County? Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 E. Seven Mile Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Walter John Fahrenholz

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	218-12-3370

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Mary P. Fahrenholz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/4/87

8. AGE: Years	Months	Days	If less than one day
59	0	5	hr. min.

9. Birthplace Wyoming (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Mr. Henry Fahrenholz
13. Birthplace New York

MOTHER
14. Maiden Name Catherine Mc Elroy
15. Birthplace New York

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) JAN 21 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946, at 6 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1940 to Jan 19 1946. and that I last saw him alive on Jan. 19 1946.

Immediate cause of death	Duration
? Cerebral accident	
Due to Chronic glomerulonephritis and hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Chronic glomerulonephritis Hypertensive Cardio-Vascular

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford W. Kirk Jr. M.D.
Address Union Memorial Hosp. Date signed 1-19-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G36577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G36577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie F. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Clay Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1860

8. AGE: Years	Months	Days	If less than one day
About 85	11	6	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER — 12. Name	John McLaughlington
FATHER — 13. Birthplace	Ireland
MOTHER — 14. Maiden Name	Celia Hopkins
MOTHER — 15. Birthplace	Ireland

16 (a) Informant Thomas P. Kelly
(b) Address 1414 Fidelity Royal Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Md.

18 (a) Funeral director Hudson, Rooney & Ford
(b) Address 1217 E. Fort Ave

19 (a) JAN 21 1946 (Date rec'd by registrar) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1946 at 12 02 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 - 1944, to January 1946 and that I last saw h. alive on Jan. 12 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. arteriosclerosis	
Due to	
Other Conditions Chr. Nephritis Myocarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Jacobs M. D.
Address 1700 Eutaw Pl. Date signed Jan 20-1946

VS 150

G36578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

✓ G36578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Edmund St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lulu M. Johnson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wm. Edward McK.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov. 9 1886
8. AGE: Years 59 | Months 2 | Days 9 | If less than one day hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: James B Nichols
13. Birthplace: Louisburg N C

MOTHER
14. Maiden Name: Gertrude E Rothrock
15. Birthplace: Baltimore Md

16 (a) Informant: Wm. Edward L Johnson
(b) Address: 709 Edmund St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Md
18 (a) Funeral director: Wilson Lodge
(b) Address: 1219 W Fort St
19 JAN 21 1946 (Date rec'd by registrar) Harding [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946, at 10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1945 to 1/18 1946, and that I last saw her alive on 1/18 1946

Immediate cause of death	Duration
Circulatory failure	24 hrs.
Due to Rheumatic + arteriosclerotic heart disease	45 yrs. +
Due to	
Other Conditions Biliary stasis	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C Edward Leach
Address 14 E. Eager St Date signed 1/18/46

VS 150

X

G36579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G36579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 S. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rinda C. Price

3 (b) If veteran, name war W | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband Henry W. Price | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27th 1899

8. AGE: Years 46 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Cambridge Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name August Bell
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Cambridge Md

16 (a) Informant Henry W. Price
(b) Address 909 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St Baltimore, Md

19 (a) JAN 21 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19th 1946, at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1945 to Jan 19 1946 and that I last saw her alive on Jan 18 1946

Immediate cause of death: Respiratory failure — Duration

Due to Chronic Glomerulo-nephritis

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Shorofsky M. D.
Address 601 N. Monroe St. Date signed 1/20/46

VS 150

G36580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1700

Registered No. G36580

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Ayer Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mariah Johnson
(b) Address 1418 Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director E. Leroy O. Wilson
(b) Address 1000 Arch St Ley and

JAN 21 1946 (Date rec'd by registrar) (Name for Williams M.D.)

MEDICAL CERTIFICATION 15

20. DATE OF DEATH January 17, 1946, at 1:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Skull fracture
Contusion of brain
Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6:25 P.M. 1-12-46 10/2 M.
(b) Where did injury occur? In front of 720 Eman St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Benedict Skaturski M.D.
Medical Examiner.
Date signed January 17, 1946

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G36581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 Bolton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. K. HOWAT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Reginald K. Howat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1859

8. AGE: Years	Months	Days	If less than one day
87	0	4	hr. min.

9. Birthplace: A. A. Co., Md. (Town, county, and state)
10. Usual Occupation: at home
11. Industry or business

FATHER
12. Name: P. Dorsey Carr
13. Birthplace: A. A. Co.

MOTHER
14. Maiden Name: Sallie Higgins
15. Birthplace: A. A. Co.

16 (a) Informant: Mr. P. Y. K. Howat
(b) Address: 1025 Conn. Ave., Wash., D. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory St. Stephens Episcopal Cem
Location: Millersville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JAN 21 1946 (b) Filed [illegible] Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1945 to Jany 18 1946, and that I last saw her alive on Jany 17 1946

Immediate cause of death	Duration
Uremia	10 days
Due to Arteriosclerotic nephritis	
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis C. Hamburger M. D.
Address 1207 Eutaw Pl Date signed 1-21-46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36582

1. PLACE OF DEATH:
(a) Baltimore City; Maryland
(b) Street address
(c) Hospital or institution: Ashburton Nursing Home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE HELEN GRIFFITHS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George H. Griffiths
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1874

8. AGE: Years	Months	Days	If less than one day
71	9	15	hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Rufus McDorman
13. Birthplace Dorchester, Md.

MOTHER
14. Maiden Name Ursula Price
15. Birthplace Chance, Md.

16 (a) Informant Mr. W. David Tilghman
(b) Address 2604 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 21 1946 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946 at 11:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1946, to Jan. 18 1946, and that I last saw h[er] alive on Jan. 18 1946

Immediate cause of death	Duration
Chronic Myocarditis	
Myocardial degeneration	
Due to Arterio-sclerosis	
Hypertension	
Due to	
Other Conditions Terminal Pulmonary Edema	6-8 hrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry A. Kelly M. D.
Address 2504 St. Paul St. Date signed 1/21/46

X

G36583

AB-98476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/B

G36583

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days

(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1515 E. Monument St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1- 1906

8. AGE: Years 39 38 | Months 12 11 | Days 16 | If less than one day hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Wesley Jones

13. Birthplace Va.

MOTHER

14. Maiden Name Mary Spotwood

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 '46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location W

18 (a) Funeral director Mrs. Ethel G. Elliott Daughter

(b) Address 1129 N. Carrollton St.

19 (a) JAN 21 1946 (b) Registrar Wilmington, Del. M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17- 1946 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1946, to 1-17 1946, and that I last saw him alive on 1-17- 1946.

Immediate cause of death: Uremia — Duration 7

Due to: Chronic Glomerulonephritis — Duration 7

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature T. P. Jernigan M.D.

Address Baltimore City Hall Date signed 1-18-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36584

486770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

Registered No. G36584

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Smallwood.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William Smallwood

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 3-30-17

8. AGE: Years 28 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Home - wife

11. Industry or business

FATHER 12. Name Thomas Carter

FATHER 13. Birthplace Va.

MOTHER 14. Maiden Name Ella Berry.

MOTHER 15. Birthplace Va

16 (a) Informant Record.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 21/46 (month) (day) (year)

(c) Cemetery or crematory

Location Milford Virginia

18 (a) Funeral director Mrs. Robert A. Elliott

(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 18 1946 at 10.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 14 1946 to Jan - 18 1946 and that I last saw h[illegible] alive on Jan - 18 1946.

Immediate cause of death	Duration
Respiratory Paralysis	
Due to Paralysis of Diaphragm	
Due to ? Syringomyelia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Stephen

Address Johns Hopkins Hosp. Date signed 1-19-46

G36585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G36585 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Carolina Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES BETTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race COLORED

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Halifax Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm. Betts
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15. Birthplace Va

16 (a) Informant Robert Betts
(b) Address 1023 E. Baddle

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory
Location Danville Va

18 (a) Funeral director Mrs. R. L. Clift's Daughter
(b) Address 1129 N. Carolina

19 (a) JAN 21 1946 (Date received by registrar) (b) Huntington Williams, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946, at 9 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH General debility
due to or as a terminal 3rd degree burns
Chronic duodenal ulcer
Lobular pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-45 Baltimore Co.
(b) Where did injury occur? Bethlehem Steel Company
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Burned by slag

23. Signature Robert Lee Proctor M.D.
Medical Examiner.
Date signed Jan 28 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

G36586 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 N. Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Cohen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Milton Kunj
(b) Address 3532 Rent Ref.

17 (a) BURIAL (b) Date thereof 1-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location Phil Rd + Conklin St

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. Balto. St.

19 JAN 21 1946 (b) Huntington Hollins
(Date rec'd by local reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 14, 1946? M.
(b) Where did injury occur? 543 N. Gay St
(c) Did injury occur at home, on farm, industrial place, in public place? at Home While at work? Theater
(d) Means of injury Overcome by gas from heater

23. Signature Benedict Shuttleworth M.D.
Medical Examiner.
Date signed 1-20-46

VS 151

correct age is especially important. Physicians: please write the c... the causes of death clearly and legibly. ...tem of information should be carefully supplied. The

636587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

636587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 WARWICK AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 39 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1644 WARWICK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** IDA STEINBERG

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife BENJAMIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name MORRIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name CHIA
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (b) Date thereof 1-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila. Rd. + HAMILTON Ave

18 (a) Funeral director JACK LEWIS Inc
(b) Address 1439 E. BALTO. St

19 (a) JAN 21 1946 (b) Name of registrar for Williams, Jr.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1946 at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1946 to Jan. 20 1946, and that I last saw h[illegible] alive on Jan 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Myocarditis	
Due to Hypertension	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. E. Keedle M. D.
Address 7514 - W. North Ave Date signed 1/21/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36588 AB-98432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G36588

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James William Glance

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	M	W	MARRIED

6 (b) Name of husband or wife ELIZABETH GLANCE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 6 1879

8. AGE: Years	Months	Days	If less than one day
66	2	12	hr. min.

9. Birthplace M. BALTO. MD. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business PENNA RR.

FATHER
12. Name James Glance
13. Birthplace BALTO.

MOTHER
14. Maiden Name Matilda Schultz
15. Birthplace BALTO.

16 (a) Informant Baltimore City Hospitals (Records) 4940 Eastern Ave.
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 22/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.
18 (a) Funeral director Leily & Zeiler esse...
(b) Address JAN 1 1946 3 S. WOLFE ST.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 19 46, at 10.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 19 46 to Jan 18 19 46 and that I last saw h alive on Jan 18 19 46

Immediate cause of death	Duration
cerebral thrombosis	
Due to	
Due to	
Other Conditions Bronchopneumonia cirrhosis of the liver (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jonathan Howland M. D.
Address R C H. Date signed 1/18/46

VS 150

G36589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G36589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 ABBOTSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 ABBOTSON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLAYTON W. LEETE

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARGARET LEETE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 24 1871

8. AGE: Years	Months	Days	If less than one day
74	4	24	hr. min.

9. Birthplace HARFORD CONN. (Town, county, and state)
10. Usual Occupation STREET CLEANER
11. Industry or business BALTO. CITY

FATHER
12. Name AMOS LEETE
13. Birthplace CONN.

MOTHER
14. Maiden Name SARAH WAY
15. Birthplace CONN.

16 (a) Informant MARGARET LEETE (WIFE)
(b) Address 1702 ABBOTSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 21/46 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVE.

18 (a) Funeral director Leilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) JAN 21 1946 (Date rec'd by local registrar) (b) Harriet Witt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 17 1946, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9th 1945 to Jan 17th 1946, and that I last saw him alive on Jan 17th 1946.

Immediate cause of death	Duration
Cardio Vascular Disease	7
Due to arteriosclerosis	2
Due to chronic myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 100 N. Fulton Ave Date signed 1/22/46

VS 150

G36590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 S. CONKLING ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 S. CONKLING ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MACK

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 21 1873

8. AGE: Years 72 | Months 10 | Days 25 | If less than one day 1 hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name CHRISTOPHER MACK
13. Birthplace BALTO.

MOTHER
14. Maiden Name AMELIA ?
15. Birthplace BALTO.

16 (a) Informant MARY HESSLER (SISTER)
(b) Address 830 S. CONKLING ST.

17 (a) BURIAL (b) Date thereof JAN. 21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) Date received by Local Registrar JAN 21 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 18 1946 at 5/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/ 19 45 to 1/18 19 46
and that I last saw h[illegible] alive on 1/18 19 46

Immediate cause of death	Duration
(a) Acute Dilatation of Heart	
Due to (b) Chronic Myocardial Disease	
Due to (c) Increased Arterial Tension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Augusta V. Keller
Address 332 S. Wolfe St. Date signed 1/19/46

G36591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1672

G36591 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 Clipper Rd.
(c) Hospital or institution:
En Route to Balto. City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Clipper Road.
(If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carolyn Lee Kapp.

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 18 1944

8. AGE: Years 1 | Months 6 1/2 | Days 17 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER
12. Name Walter Robert Kapp.
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name Catherine PARSONS
15. Birthplace BALTO MD.

16 (a) Informant Parents
(b) Address 12 Clipper Road

17 (a) Burial (b) Date thereof JAN. 21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Miller & Geckler Fun.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1946, at 7:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from D.O.A. 19..., to ... 19..., and that I last saw h... alive on ... 19...

Immediate cause of death Intracranial Hemorrhage.
Died in Arrival at Balto. City Hospital.

	Duration
Due to	
Due to	
Other Conditions Meningocele.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Congenital Heart Defect

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard A. Jones M. D.
Address Balto. City Hosp. Date signed 1-17-46

VS 150

To be approved by Medical Examiner Howard J. Thurlow, M.D.

Cadle

G36592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G36592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Cadle

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Joseph W. Cadle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1866

8. AGE: Years	Months	Days	If less than one day
79	10	3	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at Home

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Mrs Frank Herbert (Wife)
(b) Address 417 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location East of E. North Ave

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St

JAN 21 1946
(Date rec'd by Registrar)

(Signature of Registrar) Huntington Hollins

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1946, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1941 to Jan 19 1946, and that I last saw h alive on Jan 18 1946.

Immediate cause of death — Duration

My auricular

Due to

Due to

Other Conditions Senile Dementia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerrett Fisher M. D.
Address 1823 N. Wash St Date signed 1/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636593

AB-98858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G36593

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Swallow Circle-Holabird
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Dangelfild

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18-1923

8. AGE: Years	Months	Days	If less than one day
22	6	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence ?
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Isaac
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Hugh A Nelson
(b) Address 303 Forstman St

JAN 21 1946 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Jan. 17- 1946, at 10.40

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1945 to 1-17 1946 and that I last saw her alive on 1-17- 1946

Immediate cause of death Pulmonary Tuberculosis Duration 2

Due to Tuberculosis & Emphysema

Due to

Other Conditions Bronchs - Pleurisy Fatal

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B Copeland Jr M. D.
Address Balt. City Hosp. Date signed 1/19/46

VS 150

G36594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 W. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 63 Burkshire Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katie G. Mc Clellan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife James H. McClellan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
77	--	--	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James W. McElroy
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Catherine Bonn
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs Catherine G. Dushane
(b) Address 63 Burkshire Rd.

17 (a) Burial (b) Date thereof 1/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert st.

19 (a) Filed [illegible] (b) Huntington Williams, M.D. Registrar

JAN 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1946, at 2.1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1944 to 1-19 1946 and that I last saw h[illegible] alive on 1-19 1946.

Immediate cause of death	Duration
Arteriosclerotic heart	3 da.
Due to Anemia (primary)	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard F. Warren M. D.
Address 2604 Garrison Blvd Date signed 1-21-46

G36595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a

Registered No. G36595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Madison Ave
(c) Hospital or institution: 914 Madison Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leona Warren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-23-46

8. AGE: Years | Months 1 7 | Days 2 27 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William H. Warren
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Brown
15. Birthplace Washington D.C.

16 (a) Informant William Warren
(b) Address 914 Madison Ave.

17 (a) Burial (b) Date thereof 1-22-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto. Md.

18 (a) Funeral director Adolphus Hall
(b) Address 710 Howard Hall Ave.

19 (a) (b) Hunter for Williams, M.E.
(Date received by local reg.)

JAN 21 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 January 19 46 at 11 20/9 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation by bed clothes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 20 January at 11 20 A. 11/4 M.
(b) Where did injury occur? 914 Madison ave.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work?
(d) Means of injury Suffocation by bed clothes

23. Signature William H. Wolfsohn M.D.
Medical Examiner
Date signed 21 January '46

Physicians: please write the causes of death clearly and legibly. The

G36596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36596

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Sophia Malachowska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (b) Date thereof Jan. 22 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JAN 24 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1946, at 3 am M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1944 to Jan. 20 1946 and that I last saw her alive on Jan. 19 1946

Immediate cause of death	Duration
Myocardial Insufficiency	2 years
Due to General Arteriosclerosis	Unknown
Due to	
Other Conditions Unknown	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 730 Broadway Date signed 1-21-46

X

G36597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36597

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Roland ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Roland ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Agnes V. Gladfelter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Charles Gladfelter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9-1856

8. AGE: Years	Months	Days	If less than one day
89	4	8	hr. min.

9. Birthplace Baltimore Md
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aaron H. Brooke
13. Birthplace Md

MOTHER
14. Maiden Name Nancy Tall
15. Birthplace Md

16 (a) Informant Mrs. Schultz
(b) Address 4010 Roland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Balto. Md

18 (a) Funeral director Wm. L. Bryan Jr
(b) Address 1512 Hollins St

19 (a) JAN 21 19(illegible) (b) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1946 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Jan 16 1946, and that I last saw her alive on Jan 16 1946

Immediate cause of death	Duration
Cardiac dilatation	min.
Due to Arteriosclerotic cardio-vascular disease.	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Wm. McTaul Jr M. D.
Address 840 W. 36th St. Date signed 1/18/46

X

G36598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered G36598

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2257 Tacoma St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2257 Tacoma St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Clara V. Forester

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Conrad L. Forester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29-1875

8. AGE: Years 70 | Months 6 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Arnold
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Allen
15. Birthplace Md

16 (a) Informant Miss Grace Forester
(b) Address 2257 Tacoma St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore Md

18 (a) Funeral director Geo. L. Boyer Jr.
(b) Address 1512 Hollins St

19 (a) JAN 21 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 720 E. Armistead Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18, 1946 at 11 M

21. I certify that death occurred on the date above stated: that I attended deceased from Jan 1 1946 to Jan 18 1946, and that I last saw h. alive on Jan 13 1946.

Immediate cause of death	Duration
Acute Hemorrhagic Pancreatitis	1 day
Due to Chronic Cholecystitis —	14 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Neil Setaro D
Address 720 E. Armistead Ave Date signed 1/18/46

G36599 JOHN V. DORSETT ✓ G36599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Omission or misinformation should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 32nd Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 W. 34½ St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean V. Dorsett

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-24-45

8. AGE: Years	Months	Days	If less than one day
	4	25	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Eugene E Dorsett
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Margaret Stambaugh
15. Birthplace Balto Md

16 (a) Informant Mr. Eugene Dorsett
(b) Address 610 W 34th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem
Location Balto. Md

18 (a) Funeral director Wm L. Boyce Jr
(b) Address 1512 Hollins St

19 (a) JAN 23 1946 (Date rec'd by registrar) (b) Huntington, West, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946, at 9 15 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Ketterer M.D. Medical Examiner.
Date signed 1-23-46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G36600 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams + Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F. Sneider

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Lillian F. Sneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1882

8. AGE: Years	Months	Days	If less than one day
63	1	15	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Charles C. Sneider
13. Birthplace Balto., Md.
MOTHER 14. Maiden Name Augusta Ellenbrook
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Lillian F. Sneider
(b) Address 2531 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) JAN 21 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19 1946, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 1-19 1946, and that I last saw h. alive on 1/19 1946.

Immediate cause of death	Duration
Cardiac decompensation (Failure)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1/19/45
Major findings of operation Negative findings
of autopsy VENTRIC. HEART-DISEASED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 1/19/46

X

G36601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G36601

PRESS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2725 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM ALBERT ROUTSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Caroline E. Routson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	4	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business

FATHER
12. Name Albert Louis Routson
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Caroline E. Routson
(b) Address 2725 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 21 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1946, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on Jan 18 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	3 min
Due to Arterio Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Samuels M. D.
Address 4309 Liberty Hts. Date signed Jan 20

VS 150

G36602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

VOID

G36602 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT NAME PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 294 Oaklee Village (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT L. BOSWORTH

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1943

8. AGE: Years	Months	Days	If less than one day
2	7	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James C. Bosworth
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Jane Lewis
15. Birthplace Relay, Md.

16 (a) Informant Mrs. Jane Bosworth
(b) Address 294 Oaklee Village

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 21 1946 (Date rec'd by registrar) (b) Huntington Wits Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19/1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16/1946 to 1/19/1946 and that I last saw him alive on 1/19/1946

Immediate cause of death	Duration
Encephalitis	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Worth Jr. M. D.
Address Bon Secours Hosp. Date signed 1/19/46

VS 150

G36603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Springfield ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife

6 (c) If married, widowed, or divorced, date and place

7. Birth date of deceased (mo., day, yr.) ~~Jan. 31 1869~~ Jan 31 1880

8. AGE: Years	Months	Days	If less than one day
66	11	17	hr. min.

9. Birthplace Baltimore, Md (Town, county and state)

10. Usual Occupation Mail collector

11. Industry or business

FATHER
12. Name Edward L. Carter
13. Birthplace King & Queen Co Va

MOTHER
14. Maiden Name Millie Wright
15. Birthplace King & Queen Co Va

16 (a) Informant James E. Carter
(b) Address 1015 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore, Md

18 (a) Funeral director Wm. Geo. H. Sheridan
(b) Address 1631 Druid Hill Ave for Williams, Mgr

19 (a) Jan 21 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1946, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 1-18 1946 and that I last saw h.e.m. alive on 1-17 1946

Immediate cause of death Cerebral Hemorrhage — Duration un-determined

Due to Hypertensive cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald M. D.
Address 944 W Carey St Date signed 1/18/46

(OVER)

G36604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36604

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 Dukeland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 Dukeland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Adams

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Harry T. Adams
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 20, 1880
8. AGE: Years 65 | Months 11 | Days 28 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Thomas Watts
13. Birthplace St Marys Co Md

MOTHER
14. Maiden Name Sara Hogg
15. Birthplace Va

16 (a) Informant Sarah Hampton
(b) Address 2020 Dukeland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md
18 (a) Funeral director Wilson Conway
(b) Address 1217 Park Ave for Williams, Mgr.
19 (a) Filed by registrar JAN 21 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1946, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to Jan 18 1946, and that I last saw her alive on Jan 11 1946.

	Duration
Immediate cause of death: Pernicious Anemia	7 yrs
Due to:	
Due to:	
Other Conditions: Arteriosclerotic CVD	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Laurence Hammack M. D.
Address 32 N Fallsd Date signed 1-20-46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636605

BALTIMORE CITY HEALTH DEPARTMENT X 106a

CERTIFICATE OF DEATH

Registered No. 636605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/4 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 South Camp Meade Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Lynn Parks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1945

8. AGE: Years	Months	Days	If less than one day
—	10	26	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John F. Parks
13. Birthplace Penna

MOTHER
14. Maiden Name Ruth B. Marlatt
15. Birthplace Ohio

16 (a) Informant John F. Parks
(b) Address 502 S. Camp Mead Rd

17 (a) Burial (b) Date thereof Jan 23-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Balto Co. Md

18 (a) Funeral director Pratt & B. M. Walter
(b) Address Pratt Structe Co

19 (a) JAN 21 1946 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1946, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1946 to 1/20 1946, and that I last saw h[illegible] alive on 1/20 1946.

Immediate cause of death	Duration
Acute Laryngo-Tracheo Bronchitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 1/20/46

VS 150

G36606

BALTIMORE CITY HEALTH DEPARTMENT

TN. 98634 CERTIFICATE OF DEATH 13 B Registered No. G36606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-day
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Ramsay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nick Yovakimoglou

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years ? | Months | Days | If less than one day hr. min.: 54

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jordan Yovakimoglou
13. Birthplace Greece

MOTHER
14. Maiden Name Ann
15. Birthplace Greece

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 46 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Wilkens Ave & Rac

18 (a) Funeral director Lannon-Stonebraker Funeral Home Inc
(b) Address 438 E North Ave
(c) Registered by (Date received by Registrar) JAN 21 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18th 1946 19 , at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 19 46 Jan. 18 19 46 and that I last saw him alive on Jan. 18th 19 46

Immediate cause of death: Meningitis Pneumonia — Duration

Due to: Pyelonephritis

Due to: diabetes mellitus

Other Conditions: Arteriosclerosis generalized Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pulmonary Tuberculosis

of autopsy: At place

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 1-19-46

VS-150

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Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTED WHITE PAPER ONLY, WITH UNFADING INK.

G36607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

G36607
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3340 Virginia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3340 Virginia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha Amelia Trout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Walter C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1888

8. AGE: Years 57 | Months | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John F. Halsclaw
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia
15. Birthplace Pa.

16 (a) Informant Mrs. Joseph Chiquanna
(b) Address 2511 W. Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. + Gay St.

18 (a) Funeral director Harry H. Wittke
(b) Address 410 E Edmondson Ave

19 (a) Date received Jan 21 1946 (b) Registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19/46. 1946 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946, to Jan 19 1946, and that I last saw h[illegible] alive on Jan 19 1946.

	Duration
Immediate cause of death: Angina Pectoris	1/5/46
Due to: Bronchitis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Harry D Bubert M. D.
Address 1803 Park Heights Ave Date signed 1/19/46

VS 150

G36608 — BALTIMORE CITY HEALTH DEPARTMENT — G36608

CERTIFICATE OF DEATH 49a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County –
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. High St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Geneva Mobley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
33	–	–	hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Albert Mobley
13. Birthplace Unknown

MOTHER
14. Maiden Name Rose McClure
15. Birthplace Unknown

16 (a) Informant (Patient)
(b) Address

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)

(c) Cemetery or crematory Rockhill S.C.
Location

18 (a) Funeral director Joseph B. Gabriel
(b) Address 2434 N. Central Ave.

19 (a) [illegible] (Date rec'd by local registrar) (b) Jon Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1946, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1946 to Jan 17 1946, and that I last saw her alive on Jan. 17, 1946

Immediate cause of death: Abdominal carcinomatosis if possible Metastasis to Liver — Duration 4-5 mos.

Due to Carcinoma of ovary — Duration 4-6 mos

Due to

Other Conditions Ascites, Anemia

(Include pregnancy within 3 months of death)

Date of operation January 11, 1946

Major findings of operation 2500 cc. of ascitic fluid containing malignant cells.

If autopsy did Carcinomatosis of ovary & peritoneum

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Hamburger M.D.
Address Mercy Hospital Date signed 1/17/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G36609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36609 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F. Roberts

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Anna Brial
6 (c) If alive, give age 94 years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1852

8. AGE: Years	Months	Days	If less than one day
89	11	10	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Joseph F. Roberts
13. Birthplace Maryland

MOTHER 14. Maiden Name Eliza Jane Largaree
15. Birthplace Balto, Md.

16 (a) Informant Mrs Anna Roberts
(b) Address 900 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St.

JAN 21 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1941 to Jan 18 1946 and that I last saw him alive on Jan 18 1946

Immediate cause of death
Chronic Myocarditis
Due to Senile Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1 yr.
3 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Bullock M. D.
Address 207 Fort Ave Date signed 1-16-46

VS 150

G36610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G36610 Registered No.

MB #98568

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 N. Bradford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Cora Tawney

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick W. Tawney Henry Tawney

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1884

8. AGE: Years 54 Months 2 Days 29 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Hills Hiltz
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Conower
15. Birthplace Maryland

16 (a) Informant Frederick W. Tawney
(b) Address Balto. City Hospitals (Records) 4940 Eastern Ave. 1507 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Milton Ave & Rose St.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road.

19 JAN 21 1946 (b) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1946, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Jan 1946 to 20 Jan 1946 and that I last saw h.. alive on 20 Jan 1946

Immediate cause of death Uremia

Due to Kidney failure as a result of Interstitial Nephritis

Due to Primary Ca of gall bladder with secondary spread to liver and lungs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 12/20/45
Major findings of operation: Ca of gall bladder - generalized carcinomatosis
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Mark M.D.
Address Baltimore City Hospitals Date signed 20 Jan

VS 150

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36611.1

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 206 days
(e) Length of stay in Baltimore (yrs., mos., or days) 207 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Stillwater
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Campbell, Aloysius Joseph

3 (b) If veteran, name war

3 (c) Social Security Account No. 091-12-0474

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Nora Higgins Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1889

8. AGE: Years	Months	Days	If less than one day
56	1	18	hr. min.

9. Birthplace Crescent, NY (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Solomon Campbell
13. Birthplace Belfast, Ireland

MOTHER
14. Maiden Name Bridget Burns
15. Birthplace Roscomon, Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/21/46 (month) (day) (year)
(c) Cemetery or crematory
Location Mechanicsville, N. Y.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 21 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946, at 3:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945, to Jan. 20 1946, and that I last saw him alive on Jan. 20 1946

Immediate cause of death Carcinoma of larynx with cervical metastasis — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emerson L. Gledhill
E.L. Gledhill, P.A. Surgeon
Address US PHS Date signed 1/21/46 M.D.

US Marine Hospital, Balto, Md.

VS 180

G36612 G36612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1365 N. Calhoun St.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1365 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elliott Harrington

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Minnie Harrington
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1902

8. AGE: Years	Months	Days	If less than one day
43 44	2	17	✓ hr. ✓ min.

9. Birthplace Marlborough, S.C. (Town, county, and state)
10. Usual Occupation Plumber's Helper
11. Industry or business ✓

FATHER
12. Name James Harrington
13. Birthplace S.C.

MOTHER
14. Maiden Name Laura Harrington
15. Birthplace S.C.

16 (a) Informant Minnie Harrington (Wife)
(b) Address 1365 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.
18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Fremont St. Huntington Apartments, Md.
(a) Date received (by Registrar) (b) Registrar

JAN 21 1946

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946, at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1946, to Jan 19 1946, and that I last saw him alive on Jan 19 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature G. Franklin Kultgen M. D.
Address 1543 Pa. Ave. Date signed 1/21/46

G36613

BALTIMORE CITY HEALTH DEPARTMENT

CWK-98557

CERTIFICATE OF DEATH 94a

Registered No. G36613

The entry of every item of information should be carefully supplied. Typewriting, with UNFADING INK, is preferred. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60- 1- 5- LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John Daniel Schaller

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marian Dean Schaller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1885

8. AGE: Years	Months	Days	If less than one day
60	1	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business GUARD

FATHER
12. Name Chris Schaller
13. Birthplace Maryland

MOTHER
14. Maiden Name Sara McGusker
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (b) Date thereof JAN. 23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.
18 (a) Funeral director Leillyn Geiler inc.
(b) Address 403 S. WOLFE ST.
19 (a) JAN 21 1946 Huntington Williams, Md.
(Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1946 to Jan. 19 1946 and that I last saw h. in alive on Jan. 16 1946

Immediate cause of death	Duration
Coronary Thrombosis	
Cardiac Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 1-21-46

VS 150

G36614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32B

G36614 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2567 Kirk Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2567 Kirk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Veronica T. Koehler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry C. Koehler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1885

8. AGE: Years 60 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Assembled Caps

11. Industry or business Lee Cap Co.

FATHER
12. Name Aloysius Hofman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Theresa Hagman
15. Birthplace Balto. Md.

16 (a) Informant Mr. Edmund Koehler
(b) Address 2567 Kirk Ave

17 (a) Burial (b) Date thereof 1-22-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John F. Miller Jr.
(b) Address 2435 E. Oliver St

19 (a) (b) Washington Blvd
(Date rec'd by registrar)

JAN 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1945 to Jan 19 1946 and that I last saw h[im] alive on Jan 16 1946

Immediate cause of death: Pneumonia, Bronchial

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Knox Insley M. D.

Address 2436 E. Baltimore St Date signed Jan 21 1946

G36615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G36615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Wks
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Chatham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret L. Myers (MARGARET LINDSLEY MYERS)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1875

8. AGE: Years	Months	Days	If less than one day
70	10	15	hr. min.

9. Birthplace St. Louis, Mo. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Grice Myers
13. Birthplace Penna.

MOTHER
14. Maiden Name Lucretia Lindsley
15. Birthplace Washington, D.C.

16 (a) Informant Mr. George N. Queen- nephew
(b) Address 3156 Piedmont Road, N.E. Atlanta, Ga.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Registered by registrar) (b) Registrar

JAN 21 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1946, at 1:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1945 to 1/20 1946 and that I last saw her alive on 1/20 1946

Immediate cause of death	Duration
Respiratory Arrest	
Due to Cachexia	6 days
Due to Carcinomatosis	5 years
Other Conditions Fibromyoma uteri	40 years

(Include pregnancy within 3 months of death)
Date of operation 1/7/46
Major findings of operation: Fibromyoma uteri
of autopsy: Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Chenin M. D.
Address Sinai Hospital Date signed 1/20/46

G36616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36616 Registered No.

The information should be carefully supplied. The causes of death clearly and legibly. Physicians: please write the c... especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DEceased:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John J. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Johns Hopkins Medical School JAN 21 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19. (a) JAN 21 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1946, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert A. Strahan M.D.
Medical Examiner.
Date signed Jan 14 1946

2231

G36617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G36617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital | 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 N. Parrish Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 16 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 21 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 2 - 1946, at 11 15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio-vascular Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-2-46

VS 151

230

Physicians: please write the causes of death clearly and legibly. The information requested is extremely important.

636618

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 636618

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Woodbern Ave & Beauregard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Found: Woodbern & Beauregard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 16 1946

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 21 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions Incarcerated Ventral Hernia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stutarelic M.D.
Medical Examiner.
Date signed 12/30/45

5229

File 636619

CWK-96967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. 636619

Every item of information should be carefully supplied. PRINT PLAINLY, WITH UNFADING INK. Every item is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 11
(e) Length of stay in Baltimore (yrs., mos., or days) 60- 10- 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25-1885

8. AGE: Years	Months	Days	If less than one day
60	10	15	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel Estay
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address
JAN 21 1946 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1946, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1945, to Jan. 10 1946, and that I last saw h. alive on Jan. 10 1946

Immediate cause of death	Duration
Cardiac failure,	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B C H Date signed 1/12/46

VS 150

G36620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36620 Registered No. 107

AB-73403

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs- 8mos-22days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 S. Paca Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Seymour Carman CARMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7- 1870

8. AGE: Years 75 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace N. Y.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Carman
13. Birthplace N.Y.

MOTHER
14. Maiden Name Margaret
15. Birthplace N.Y.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 21 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12- 1946, at 1.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1946, to 1-12 1946, and that I last saw him alive on 1-12- 1946

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 1/12/46

6233

X

VS 150

G36613

BALTIMORE CITY HEALTH DEPARTMENT

CWK-98557

CERTIFICATE OF DEATH 194a

Registered No. G36613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60- 1- 5- LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2945 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
John Daniel Schaller

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marian Dean Schaller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1885

8. AGE: Years 60 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation RETIRED
11. Industry or business GUARD

FATHER
12. Name Chris Schaller
13. Birthplace Maryland

MOTHER
14. Maiden Name Sara McCusker
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 23/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Tillyer Geiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) JAN 21 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 19 46 to Jan. 19 19 46 and that I last saw h. in alive on Jan. 16 1946.

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Cardiac Failure
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: None
of autopsy: Waive

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 1-31-46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36622 BALTIMORE CITY HEALTH DEPARTMENT G36622

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dft
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2836 Kentucky Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Weiss

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John Weiss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31st 1883

8. AGE: Years	Months	Days	If less than one day
63	11	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frank J. Nagel
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Kirschbaum
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Frank Smick
(b) Address 1663 Darley Ave.

17 (a) Burial (b) Date thereof 1/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 (a) 1946 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18, 1946, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sulinski M.D.
Medical Examiner.
Date signed 1/18/46

G36623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1060

G36623 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Hollins St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Hollins St
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony W. Bierhaus

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 1892

8. AGE: Years	Months	Days	If less than one day
53.	2	29.	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Boilermaker
11. Industry or business

FATHER
12. Name John Bierhaus
13. Birthplace Germany

MOTHER
14. Maiden Name Gerlemoth
15. Birthplace Germany

16 (a) Informant Mrs B. Schwartz
(b) Address 1906 N Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 22 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John F Gonzales Sr
(b) Address 907 N Gilmor St

JAN 21 1946 (Date filed by registrar) (c) Signature of Registrar Thomas Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1946, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 19 1946, and that I last saw it alive on Jan 18 1946.

Immediate cause of death Pulmonary Embolism
Due to Chronic Interstitial Nephritis
Due to Hypertension
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 1 hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature James N Lazenby M.D.
Address 7 E Mt Vernon Pl Date signed 1/21/46

Physicians: please write the exact age in especially important. Every item of information should be carefully supplied. The to the causes of death clearly and legibly.

G36624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36624

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1846
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Carlton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lottie Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Mathews Jackson
13. Birthplace Essex Co. Va.

MOTHER
14. Maiden Name Harriet Campbell
15. Birthplace Va.

16 (a) Informant Sally Alley - sister
(b) Address 108 N. Carlton St.

17 (a) Burial (b) Date thereof Jan. 22-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Jan 22 1946 (Date rec'd by registrar) Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1946, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Leibowitz M.D.
Medical Examiner.
Date signed 1/18/46

VS 151

Important: Physicians: please write the causes of death clearly and legibly.

G36625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G36625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 N. Gilmor Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 N. Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT BALL

3 (b) If veteran, name war: World War#2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1912

8. AGE: Years 33 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Soldier

11. Industry or business

FATHER
12. Name Vincent Ball, Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Florence Gant
15. Birthplace Balto., Md.

16 (a) Informant Florence Ball (mother)
(b) Address 216 N. Gilmor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2229 W. Lanvale St.

19 1/21/46 (b)
(Date rec'd by registrar) Registrar

VS. 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratton M.D.
Medical Examiner.
Date signed Jan. 17 1946

X

G36626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36626 Registered No.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 Bradley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Bradley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife Allie Spencer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1881

8. AGE: Years	Months	Days	If less than one day
64	5	9	hr. min.

9. Birthplace Loudon County Round Hill Va
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Williams
13. Birthplace Round Hill Va

MOTHER
14. Maiden Name Martha
15. Birthplace London Va

16 (a) Informant Margaret Warren
(b) Address 1025 Bradley Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan 22 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Charlestown W. Va.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 JAN 21 1946 (Date rec'd by Registrar) Waiting for Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1946, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Jan 1946 and that I last saw her alive on Jan 17 1946

Immediate cause of death Congestive Heart Failure — Duration 4 yrs

Due to Essential Hypertension — Duration 4 yrs

Due to Hypertensive Heart Disease — Duration N Known

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emerson R. Julian M.D.
Address 434 E 22nd Date signed 1/21/46

VS 150

G36627

BALTIMORE CITY HEALTH DEPARTMENT 817 Hamilton Ave

CERTIFICATE OF DEATH 131a

Registered No. G36627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 N Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 N Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15/1883

8. AGE: Years	Months	Days	If less than one day
62 63	3	6	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles H Jordan Sr
13. Birthplace Va

MOTHER
14. Maiden Name Emmaline Jordan
15. Birthplace Va

16 (a) Informant Sophia Palmer
(b) Address 1112 N Carey St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 1-21-46 (month) (day) (year)
(c) Cemetery or crematory Smith Field Va
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

JAN 21 1946 Huntington Williams NF
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1946, to Jan 21 1946, and that I last saw him alive on Jan 20 1946.

Immediate cause of death Chronic Nephritis

	Duration
Due to	10 yrs
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. C. Pettigrew M. D.
Address 817 Hamilton Ave Date signed Jan 24 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPE OR PRINT, WITH UNFADING INK.

G36628

BALTIMORE CITY HEALTH DEPARTMENT

CMK-97693

CERTIFICATE OF DEATH

512

G36628 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 15
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 W. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John Bachelder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7-1875

8. AGE: Years	Months	Days	If less than one day
70	3	11	hr. min.

9. Birthplace Massachusetts (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Robert Bachelder
13. Birthplace Mass.

MOTHER — 14. Maiden Name Martha Martin
15. Birthplace Mass.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 22/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1805 Eastern Ave

19 (d) JAN 21 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1946, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1945, to Jan. 18 1946, and that I last saw him alive on Jan. 18 1946.

Immediate cause of death: 1. Coronary Occlusion — Duration: 1 Mo.
With Infarction of Myocardium — 1 week
2. Pulmonary Edema — 1 week
Due to: 3. Hydrothorax Bilat. — 1 mo
4. Carcinoma of Prostate — 1 year
Due to: 5. Cystitis, Chronic — 8 mos
6. Bilateral Hydroureters — 6 mos
Other Conditions: 7. Bilateral Pyonephrosis — 6 mos
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lush C. Tallerville M. D.
Address Baltimore City, Md. Date signed Jan 21, 1946

VS 150

G36628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36628 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice L. Stone

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna M. Miller
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 1, 1899

8. AGE: Years	Months	Days	If less than one day
46	6	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Hair Dresser
11. Industry or business

FATHER
12. Name Robert F. Stone
13. Birthplace Wash.

MOTHER
14. Maiden Name Anna Christy
15. Birthplace Md

16 (a) Informant Anna M. Stone
(b) Address 2505 Ellamont St

17 (a) Burial (b) Date thereof Jan. 22-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem.
Location Holt Ave & Greenmount Ave

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1910 Eastern Place

19 (a) JAN 21 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1946, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19 1946 to 1/19 1946 and that I last saw him alive on 1/19 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1½ hrs.
Due to Arteriosclerosis C.V. Disease	
Due to Previous attack in July '45 Confirmed by EKG	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Martin E. Strobel M.D.
Address MD Gen. Hospital Date signed 1/19/46

VS 150

G36630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1712

Registered No. G36630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20n
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5622 Greenspring Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wm. B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1905

8. AGE: Years	Months	Days	If less than one day
40	7	18	hr. min.

9. Birthplace Waterbury, Conn. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Frank Winestine
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie Stern
15. Birthplace Russia

16 (a) Informant Wm. B. Schwartz
(b) Address 5622 Greenspring Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 3600 E. Balto. St. Cem.

18 (a) Funeral director Sol Levinson & Bro.
(b) Address 124-1126 W. Mosher Avenue

JAN 22 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1946 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Contusion of brain

Due to

Other Conditions Multiple fractures, lacerations, contusions, abrasions, burns

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-20- at 8.45 P.M.
(b) Where did injury occur? Bellgrave Ave. & [illegible] County Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by trolley

23. Signature Thomas J. Mercer M.D. Medical Examiner.
Date signed 1-21-46

VS 151

Please write the causes of death clearly and legibly. Any necessary explanations by physicians; please write on reverse side.

63631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

N 46E

Registered No. 63631

Every item of information should be carefully supplied. Type or write in INDELIBLE WHITE PENCIL, WITH UNFADING INK. Every item must be answered. Write "None" where necessary to complete the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3828 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Samuel Shaikewitz

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena Floam

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 5, 1889

8. AGE: Years: 56 | Months: 3 | Days: 15 | If less than one day: hr. min.

9. Birthplace: New York City
(Town, county, and state)

10. Usual Occupation:

11. Industry or business: C. P. A,

FATHER
12. Name: Samuel Shaikewitz
13. Birthplace: Russia

MOTHER
14. Maiden Name: Anna Watzman
15. Birthplace: Russia

16 (a) Informant: Lena Shaikewitz
(b) Address: 3828 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: January 22, 1946 (month) (day) (year)
(c) Cemetery or crematory: Bnai Israel Cemetery
Location: Southern Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

JAN 22 1946 (c) Date received by Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-20 1946, at 10 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1946, to 1-20 1946, and that I last saw h[illegible] alive on 1-20 1946

Immediate cause of death	Duration
Adenocarcinoma of Colon & metastasis	
Due to liver	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: 1946 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Arnold Katz M. D.
Address: Sinai Hosp Date signed: 1-22-46

VS 190

G36632 27317

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 577

Registration No. G36632

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Martins Ferry
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Virginia Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia O. McCullough

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Frank McCullough
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 11-12-07

8. AGE: Years	Months	Days	If less than one day
38	2	9	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George H Tucker
13. Birthplace Virginia

MOTHER
14. Maiden Name Jona Teel
15. Birthplace Virginia

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory
Location Parkersburg W. Va

18 (a) Funeral director Nutter & Tucker & Son
(b) Address 30th & Pennsylvania Ave

19 (a) (Informant's signature) (b) Huntington West Virginia

JAN 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21, 1946, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Jan 21 1946 and that I last saw her alive on Jan 21 1946

Immediate cause of death	Duration
Post operative complications - BILATERAL CEREBELLAR EXPLORATION	
Due to Question - Brain tumor ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 15 Jan 1946
Major findings of operation Obstruction at aqueduct of Sylvius.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John William Hellman M. D.
Address Johns Hopkins Hospital Date signed Jan 21, 1946

X

G36633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 9-2
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Montebello Terrace (Usual place of abode) Lake Montebello Drive
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bessie G. Parker

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Walter W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1881 1879

8. AGE: Years 66 | Months 11 | Days xx'3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Companion
11. Industry Housework

FATHER
12. Name John Fleming Parke
13. Birthplace Maryland

MOTHER
14. Maiden Name Alberta Virginia Grumbine
15. Birthplace Maryland

16 (a) Informant Mrs. Wm. W. Amoss
(b) Address 37 Kenwood Ave, Kenmore N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 JAN 22 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1946, at 6 34 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1946 to Jan. 21 1946, and that I last saw her alive on Jan. 21 1946.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to Hypertensive Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gayle B Amoss M. D.
Address 1211 M. St. Date signed 1-21-46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WRITE PLAINLY, WITH UNFADING INK.

G36634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G36634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 E. Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C. Yeaker

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 212-10-9617

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1919

8. AGE: Years	Months	Days	If less than one day
26	9	16	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business Radio

FATHER
12. Name Paul M. Yeaker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Teresa Newbrook
15. Birthplace Balto. Md.

16 (a) Informant Teresa Yeaker
(b) Address 1244 E. Fort Ave

17 (a) Burial (b) Date thereof 1/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JAN 22 1946 (b) Huntington Willard Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946 at 11:50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Exanguination

Due to Gun shot wound of abdomen

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 20, 1946 at M.
(b) Where did injury occur? 1036 E. Fort Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 1-21-46

G36635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G36635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 Homewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Bull

3 (b) If veteran, name war N

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John A. Bull

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5th 1865

8. AGE: Years 80 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace York Co. Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Wm Koller
13. Birthplace Pa.

MOTHER
14. Maiden Name Lavina
15. Birthplace Pa

16 (a) Informant John A. Bull
(b) Address 2110 Homewood Ave

17 (a) Burial (b) Date thereof 1/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) JAN 22 1946 (b) Twitty & Williams
(Date rec'd by Registrar) Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20th 1946 9 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Jan 20 1946 and that I last saw h[illegible] alive on Jan 20 1946

Immediate cause of death Carcinoma of Uterus — Duration 3 yrs +

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George D. Lefevre M. D.
Address 420 S. Patterson Pk (Date signed 1/24/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G36636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3524 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Park Heights ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Phillip Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-2059

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 63 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Bessie Snyder
(b) Address 3524 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem
Location Wash. Boulevard

18 (a) Funeral director Jack Lewis Inc
Address 1716 E Balto St

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1946, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1946, to Jan 21 1946, and that I last saw h[illegible] alive on Jan 21 1946.

	Duration
Immediate cause of death: Heart Failure	
Due to: Coronary Heart Disease	15 years
Due to:	
Other Conditions: none	

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel V. Jonas M. D.

Address 3431 Park Hts ave Date signed Jan 21, 1946

V# 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. G36637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hosp - 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Seguora
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Morton Dintzer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1934

8. AGE: Years	Months	Days	If less than one day
12			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name Raymond I Dintzer
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rose Dintzer Frank
15. Birthplace Balto Md

16 (a) Informant Raymond I Dintzer
(b) Address 3303 Seguora Ave

17 (a) Burial (b) Date thereof 1-22-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Rosedale

18 (a) Funeral director Jack Lewis Inc
(b) Address 1609 E Balto St

19 (a) [illegible] (b) [illegible]
(Date received by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1946, at 2:10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of head.
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 20 1946 15/11 M.
(b) Where did injury occur Front of 3303 Seguora
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shooting

23. Signature Benedict Skibarelic M.D.
Medical Examiner.
Date signed 1-21-46

G36638

AB-98396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G36638 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 866 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Summerville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- 60?

8. AGE: Years 60? Months Days If less than one day hr. min.

9. Birthplace (Town) (County) (State) Unable to give any information on admission

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Baltimore City Hospitals(Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 748 Reland Hill Ave

19 JAN 22 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16- 1946, at 9.15 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8- 19 46 to 1-16 1946, and that I last saw h im alive on 1-16- 19 46.

Immediate cause of death cerebrovascular accident

Due to arteriosclerosis

Due to

Other Conditions Cardiac failure hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.

Address R.C.H. Date signed 1/20/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36639

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6m, 3dy
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Neal

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1876

8. AGE: Years	Months	Days	If less than one day
69 70	6	15	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Neal
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Sapp
15. Birthplace Md.

16 (a) Informant Mr. Robert D. Clare
(b) Address 1900 St. Paul St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 21 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/46 19 , at 5:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1945 to 1/15 1946 and that I last saw him alive on 1/15 1946

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease with Decompensation — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.A. Bailey M. D.
Address Mercy Hosp. Date signed 1/15/46

VS 150

5235

G36640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G36640 Registered No.

Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPEWRITER, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. Balt. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5243 Cordelia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Castel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-1946

8. AGE: Years	Months	Days	If less than one day
			11 hr. min.

9. Birthplace Balt md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Dennis Castel
13. Birthplace Balt md

MOTHER 14. Maiden Name Joan Matthews
15. Birthplace Balt md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 16 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946, at 1 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1946 to Jan 15 1946, and that I last saw h alive on Jan 15 1946.

Immediate cause of death	Duration
(a) Asphyxia	
Due to Premature Birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

E 5236

G36641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G36641 Registered No.

Please answer questions carefully and completely. Be certain to state the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Ascension (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lemmy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/14/46

8. AGE: Years | Months | Days | If less than one day hr. 30 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Richard Lemmy
13. Birthplace S. C.

MOTHER 14. Maiden Name Creola Morant
15. Birthplace S. C.

16 (a) Informant Creola Lemmy.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1946 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1946 to 1-14 1946 and that I last saw h. EX alive on 1-14 1946

Immediate cause of death Respiratory failure — Duration

Due to Fetal atelectasis

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death).

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R.B. Jarman M.D.
Address Univ. Hosp Date signed 1-19-46

VS 3

8239 X

G36642 ✓ G36642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

Registered No. ✓

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ. Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 So. Poppleton
(If rural give location)
(e) Citizen of foreign country? Eng (Yes or No) ✓
If yes, name country —

3 (a) FULL NAME Baby Boy Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/21/45

8. AGE: Years	Months	Days	If less than one day
—	1/21	25	— hr. — min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Charles
13. Birthplace —

MOTHER
14. Maiden Name Adams
15. Birthplace —

16 (a) Informant mother
(b) Address above

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory ____
Location University Medical School JAN 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address ____

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1946, at 9? P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1946 to 1/16 1946, and that I last saw h[illegible] alive on 1/16, 1946.

Immediate cause of death Pneumonia	Duration
Due to Anemia	
Due to Dehydration	
Other Conditions Cardiac	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature [illegible]
Address Univ. Hosp. Date signed 1/17/46 M. D.

VS 150

5238 X

G36643 G36643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richwood & Green
(c) Hospital or institution: Univ Hosp. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 5 Bethel St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lee.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S.

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1946.

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Dorothy
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address Thos. J. Williams, M.D.

19 JAN 22 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1946, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1946, to 1/14 1946, and that I last saw him alive on 1/14 1946

Immediate cause of death	Duration
Bilat. patchy atelectasis	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Robertmark M. D.
Address Univ Hosp Date signed 1/16/46

VS 150

237 X

G36644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G36644 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5308 Beaufort Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5308 Beaufort Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nellie V. Starke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Edwin Starke

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1890

8. AGE: Years	Months	Days	If less than one day
55	4	3	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Edward F. Constantine

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Susan Wilder

15. Birthplace Balto. Md.

16 (a) Informant Mr. Edwin Starke

(b) Address 5308 Beaufort Ave

17 (a) Burial (b) Date thereof Jan 22/46 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mem. Cathedral

Location Old Frederick Rd.

18 (a) Funeral director Krause Funeral Home

(b) Address 216 N. Charles St.

19 (a) (Signature of registrar) (b) Huntington Wilson M.D.

JAN 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1946, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946, to Jan 19 1946, and that I last saw h[illegible] alive on Jan 19 1946.

Immediate cause of death	Duration
Acute Cardiac Emphysema	
Due to	
Due to	
Other Conditions Pneumonia	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward F. Cahn M. D.

Address 956 Cathedral St Date signed 1/21/46

X

G36645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1-9

G36645 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 Woodyear Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/12/46

8. AGE: Years	Months	Days	If less than one day
			28 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name Gertrude Cole

15. Birthplace Md.

16 (a) Informant Gertrude Cole

(b) Address 1139 Woodyear Av

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School JAN 19 1946

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 22 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1946 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1946 to 1-13 1946 and that I last saw h.i. alive on 6 a.m. 1946

Immediate cause of death (a) Premature

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Wiles Drake M. D.

Address Univ. Hosp. Date signed 1-14-46.

correct age is especially important. Physicians: please write the ... Every item of information should be carefully supplied. Th... the causes of death clearly and legibly.

VS 150

240

G36646 X V G36646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County Carroll
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Davis.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/12/46

8. AGE: Years	Months	Days	If less than one day
			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Emma Davis.
15. Birthplace Lutherville Md.

16 (a) Informant Emma Davis.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946 at 6:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 12 1946 and that I last saw him alive on Jan 12 1946

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mates E. Drake M. D.

Address Univ Hosp Date signed 1-13-46

VS 150

X 241

G36647 ✓ G36647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond Ave
(c) Hospital or institution:
University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Green Village St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/45

8. AGE: Years | Months | Days 20. | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Fleming
13. Birthplace

MOTHER
14. Maiden Name Evelyn Crawford
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins University Medical School JAN 19 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 22 1946 (b) by authority for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13/46. 1946 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1945, to 1/13 1946, and that I last saw h alive on 1/13 1946.

Immediate cause of death	Duration
Epidemic diarrhoea of newborn	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature aRobert Mark M. D.
Address Union Mem Hosp Date signed 1/14/46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3242 X

G36648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1194

Registered No. G36648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ. Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore H. 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Reddind Ct.
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country —

3 (a) FULL NAME Francis E. Buckroad

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) — 12/14/45

8. AGE: Years	Months	Days	If less than one day
—	1 mo	-1	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Selmar Buckroad
13. Birthplace Md

MOTHER
14. Maiden Name Arthur Robertson
15. Birthplace N.C.

16 (a) Informant Mother
(b) Address above

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 1 91946
18 (a) Funeral director Commissioner of Health
(b) Address
19 JAN 22 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1946, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946, to 1/15 1946, and that I last saw him alive on 1/15 1946.

Immediate cause of death	Respiratory failure	Duration
Due to	Prematurity	
Due to	Atelectasis, delayed	
Other Conditions	Aspiration of vomiting	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Sandberg M. D.
Address Univ. Hosp. Date signed 1/15/46

VS 150

213 X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45B

Registered No. 636649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmont
(c) Hospital or institution: Church Home and Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Kingston Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. BLOECHER (William H. Bloecher)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married-Separated

6 (b) Name of husband or wife: Anna E. Bloecher

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1889

8. AGE: Years 56 yrs | Months 3 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Mr. John Bloecher
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Pauline Repp.
15. Birthplace Germany

16 (a) Informant Mrs. Anna Bloecher
(b) Address 500 Kingston Rd. Balto. Md.

17 (a) BURIAL (b) Date thereof Jan 22/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director L. S. Hartsock Son
(b) Address 800 Eastern Ave.

19 JAN 22 1946 (By) Instructor for Mutilated
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1946, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1946 to 1-19 1946 and that I last saw h[illegible] alive on 1-19 1946

Immediate cause of death: ~~Respiratory failure~~ Marasmus

Due to: Malnutrition & Senility

Due to: Cerebroma of Tongue with metastases

Other Conditions: Cachexia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. DeWitt Peck M.D.
Address Church Home & Hospital Date signed 1-21-46

correct age is especially important. Physicians: please write the ... item of information should be carefully supplied. The ... the causes of death clearly and legibly.

VS 150

G36650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156a ✓ Registered No. G36650

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Appleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED H. BEALL

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas W. Beall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1895

8. AGE: Years 50 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Millard F. Davis
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Phoebe Sheets
15. Birthplace Frederick Co., Md.

16 (a) Informant Mr. Thomas W. Beall
(b) Address 810 Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cem.
Location Purdum, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by Local Reg. JAN 22 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19, 1946 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Jan. 19 1946 and that I last saw h[illegible] alive on Jan. 19 1946

Immediate cause of death: Chr. infectious arthritis — Duration: 20 yrs
Due to: T
Due to:
Other Conditions: Goitre ex vinkin from Influenza and pneumonia — 6 mos.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick J. Bentley M. D.
Address 723 Medical & Sci. Bldg. Date signed 1-22-46

X

G36651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4313 Valley View Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4313 Valley View Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE J. REINKING

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wilhelmina Reinking

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 1, 1871

8. AGE: Years: 74 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Deitrich F. Reinking
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louise M. Tyler
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Wilhelmina Reinking
(b) Address: 4313 Valley View Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21/46 19 at 3 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: John R. Weis M.D. Medical Examiner.
Date signed 1/21/46

VS 151

G36652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 B

G36652 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 46 Churchhill Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 46 Churchhill Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Edith Kellum

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/1888

8. AGE: Years 57 | Months 1 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Geo Olem
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Johnson
15. Birthplace Md

16 (a) Informant Moses E Ellis
(b) Address 46 Churchhill Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1010 Montgomery St

19 JAN 22 1946 (Date received by Local Registrar) Hattie Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1946 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1946 to Jan 18 1946, and that I last saw her alive on Jan 17 1946

Immediate Cause of death: Influenza — Duration: 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature. Robert W. Haines M. D.
Address 507 W. Hamburg St Date signed 1/21/46

VS 150

G36653

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1192

G36653
Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town ~~Baltimore~~ (Linthicum)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 So. Camp Meade Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sharon Parks SHARON D. PARKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) (Single), married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25- 1945

8. AGE: Years: — Months: 10 Days: 27/26 If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John F. Parks
13. Birthplace Penna

MOTHER
14. Maiden Name Ruth B. Marlatt
15. Birthplace Ohio

16 (a) Informant John F. Parks
(b) Address 502 S. Camp Mead Rd

17 (a) Burial (b) Date thereof Jan 28-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial
Location Balto Co Md

18 (a) Funeral director B.M. Walter
(b) Address Bath + Stricker St

19 (a) 1/28/46 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1946 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1946 to 1/27 1946 and that I last saw h. alive on 1/27 1946.

Immediate cause of death	Duration
Pneumonia + Acidosis	
Due to Influenzal Pneumonia	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.

Address Md. Gen. Hospital Date signed 1/28/46

X

G36654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G36654 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR TYPEWRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 E. 39th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Robert Leon Dowell

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs. Robert Dowell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1890

8. AGE: Years	Months	Days	If less than one day
55	10	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Hauler-Steam Business
11. Industry or business

FATHER
12. Name Robt. Lee Dowell
13. Birthplace ~~Baltimore, Md.~~ VA.

MOTHER
14. Maiden Name Pearl Hope
15. Birthplace Balto., Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park. Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave.

19 (a) Huntington Williams (Registrar) (Date received by Registrar) JAN 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946, at 12.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1946 to Jan. 20 1946, and that I last saw him alive on Jan. 20 1946.

Immediate cause of death: respiratory failure — Duration

Due to: Cerebral vascular accident

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Old subacute bacterial endocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Crawford N. Kirkpatrick, Jr. M.D.
Address Union Memorial Hosp. Date signed 1-20-46

X

G36655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

G36655 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 Poplar Grove St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Mooney

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-6342

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise W. Mooney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1874

8. AGE: Years 71 | Months 1 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name John B. Mooney
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Shonhan
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Louise W. Mooney
(b) Address 1732 Poplar Grove St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 JAN 22 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

5.15

20. DATE OF DEATH January 19, 1946, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Jan 19 1946 and that I last saw him alive on Jan 19 1946

Immediate cause of death: Coronary thrombosis — Duration 2 yrs.

Due to: Heart dis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Ernest N. Kalmus, M.D.

Address 1732 Poplar Grove St Date signed 1/30/46

VS 150

G36656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G36656

To correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 - N. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Brooks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1703 Bloomfield Ave
Date received by Registrar JAN 22 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18-1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17-1946, to 1-17-1946, and that I last saw h. alive on 1-18-1946.

Immediate cause of death Respiratory failure — Duration 36 hours.

Due to Aspiration and asphyxia due to Carcinoma of Stomach -

Due to

Other Conditions Pt. had total gastrectomy

(Include pregnancy within 3 months of death)

Date of operation August 1945

Major findings of operation: Carcinoma of stomach - Metastases

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph M. Young M.D.
Address Johns Hopkins Hosp Date signed 1-18-46

X

G36657

486892.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53 E

G36657 Registered No.

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Russell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-82

8. AGE: Years 63 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Supply-man. Post Office

11. Industry or business

FATHER 12. Name Eli Russell

13. Birthplace Md

MOTHER 14. Maiden Name Jane Woolley

15. Birthplace Md

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Edgar Ely and Huntington Williams M.D.

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-18 1946 at 10.15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-16 1946 to Jan-18 1946 and that I last saw him alive on Jan-18 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinomatosis, generalized	Unknown
primary site undetermined	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Generalized Carcinomatosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Williamson M. D.

Address Johns Hopkins Hosp Date signed 1-19-46

G36658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G36658 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maizil Mc Lain

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lawrence
13. Birthplace U. S.

MOTHER
14. Maiden Name Luvinia
15. Birthplace N. C

16 (a) Informant Luvinia Lawrence
(b) Address 28 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brant Lane

19 (a) 1-22-1946 (Date rec'd by registrar) Huntington Williams JR Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946, at 12 30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Exsanguination

Due to Gunshot wound of lower abdomen severing iliac vessels

~~Other Conditions~~

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-19-46 at 12:15 A. M.
(b) Where did injury occur? Fayette & Dallas Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury? Shot during altercation.

23. Signature Benedict Skottarelis M.D.
Medical Examiner.
Date signed 1-19-46

VS 151

Please write the causes of death clearly and legibly. The certificate must be completed, signed, and returned by attending physicians promptly after death. The

6366:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

6366:59

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 3 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 S. Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H Davis ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Annie Fleet
(b) Address 8 S. Bethel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elmer A. Wilson
(b) Address 1000 Edmondson Ave

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Huntington Williams Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 January 1946 at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Syphilitic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L Skipsick M.D. Medical Examiner.
Date signed 21 January 46

X

VS 151

G36660

AB-95062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos-13days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 High Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1880

8. AGE: Years 65 | Months 2 3 | Days 29 0 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Smith (D)
13. Birthplace Md.

MOTHER 14. Maiden Name Annie ? (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22 1946 (Month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Ebony O. Wilson
(b) Address 1000 Brentley Ave

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) Arlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. ~~18~~ 17 1946, at 2.35A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28- 1945 to 1-~~18~~ 17 1946 and that I last saw h im alive on 1-~~18~~ 17 1946

Immediate cause of death	Duration
cerebrovascular accident	
Due to arteriosclerosis	
Due to	
Other Conditions bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B C H Date signed 1/18/46

(over)

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G36661 Registered No.

T. K. Every item of information should be carefully supplied. Use typewriter if possible, otherwise write the causes of death clearly and legibly. Physicians: please write correct age in especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Pinkney Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Pinkney Road. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME BECCA H. DOEPLITZ.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Doeplitz.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 6, 1868.

8. AGE: Years 77 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nathan Herstein.
13. Birthplace Germany.

MOTHER
14. Maiden Name Amelia Emerich,
15. Birthplace Germany.

16 (a) Informant Mr. Edward O. Doeplitz,
(b) Address 3407 Pinkney Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.22.46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director David Lomasheimer Son
(b) Address 1902 Eutaw Place.

19 (a) JAN 22 1946 (Date rec'd by registrar) for Wallington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 20th. 1946 at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1945 to Jany 20 1946, and that I last saw h[illegible] alive on Jany 19 1946.

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of Breast	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed

VS 150

G36662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G36662 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rossie Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1920

8. AGE: Years 25 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Clarmon County S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Warren Hicks
13. Birthplace Clarmon Co, S.C.

MOTHER
14. Maiden Name Annie Hicks
15. Birthplace Clarmon Co, S.C.

16 (a) Informant John Bailey
(b) Address 1419 Madison Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan. 22 '46 (month) (day) (year)

(c) Cemetery or crematory
Location Sumter S.C.

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St

JAN 22 1946 (Date rec'd by registrar) Mrs Kate R Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1946 at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculous caseous pneumonia, Acute Cardiac dilatation

Other Conditions Emaciation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D. Medical Examiner.
Date signed Jan 17, 1946.

the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

636663 Reg. No. 526353

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 Sidney Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude M. Norris

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1890

8. AGE: Years	Months	Days	If less than one day
55	7	0	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Wermuth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary A Schafer
15. Birthplace Baltimore

16 (a) Informant Henry Norris
(b) Address 2317 Sidney Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave E of Gay St

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Road

19 JAN 22 1946 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20th 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 45 to Jan 20 1946, and that I last saw him alive on Jan 20 19 46.

Immediate cause of death Pulmonary Edema — Duration 1 day
Due to Senile Changes — 2 years
Due to Hypertension C.V.D.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schafer
Address 3201 Ampleforth Date signed 1/22/46

VS 180

G36664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1111B

Registered No. G36664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1007 N Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucretia Rushen.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/12/1895

8. AGE: Years 50 | Months 11 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Lewis Rusk

13. Birthplace Va.

MOTHER 14. Maiden Name Lillian Norris

15. Birthplace Va.

16 (a) Informant Isaac Rushen

(b) Address 1007 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)

(c) Cemetery or crematory Lancaster Co. Va

Location Va

18 (a) Funeral director Geo. H. Kelson

(b) Address 1302 Presstman St

JAN 22 1946 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 January 1946 at 12 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Arteriol Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?

(d) Means of injury .....

23. Signature William G Kelsick M.D. Medical Examiner.

Date signed 21 January 46

VS 151

G36665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110B

Registered No. G36665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EDWARD BRAZIER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Ruth Brazier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1916

8. AGE: Years 29 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (town, county, and state)

10. Usual Occupation Welder

11. Industry or business Ship Yard.

FATHER
12. Name Leonard G. Brazier
13. Birthplace England

MOTHER
14. Maiden Name Louise Hurley
15. Birthplace Conn.

16 (a) Informant Mrs. J. V. Mulvey
(b) Address 2806 Boorman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City

18 (a) Funeral director A. Vernon Lemmon.
(b) Address 4611 Park Heights Ave

19 (a) JAN 22 1946 (b) Huntington Williams
(Date rec'd by Bd)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946 at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1945, to 1-20 1946 and that I last saw h alive on 1-20 1946

Immediate cause of death Cachexia — Duration

Due to chronic infectious granuloma, perineum

Due to

Other Conditions fibrinous pericarditis, adherent pleuritis (right)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Lawlor M. D.
Address Sinai Hosp Date signed 1-20-46

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36666 — BALTIMORE CITY HEALTH DEPARTMENT — G36666

CERTIFICATE OF DEATH 108

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N Pinedale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Foit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barania

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1883

8. AGE: Years 62 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Bernard Foit

13. Birthplace Md

MOTHER 14. Maiden Name Barbara Ochs

15. Birthplace Germany

16 (a) Informant Hoyt Percival

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Geo A Fahey

(b) Address Fulton & Fayette

19 (a) JAN 22 1946 (Date rec'd by local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1946, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945 to 1/22 1946 and that I last saw him alive on 1/22 1946

Immediate cause of death: Bilateral pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carthon T. Hall Jr M. D.

Address St. Agnes Hosp. Date signed 1/22/46

VS 150

G36667 G36667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 W Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 W Fairmount
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher Hommerbocker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine Md

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1869

8. AGE: Years 76 Months 8 Days If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Charles Hommerbocker

13. Birthplace Md

MOTHER 14. Maiden Name Annie Valine

15. Birthplace Md

16 (a) Informant Mrs Ray Belcher

(b) Address 1606 W Baltimore

17 (a) Burial (b) Date thereof 1-23-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Geo A Farley

(b) Address Fulton & Fayette

19 (a) JAN 22 1946 (b) Huntington Williams MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 19th 1946, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to JAN 19 1946, and that I last saw him alive on Jan 15 1946.

Immediate cause of death Myocardial insufficiency.
arteriosclerotic type heart disease
Due to Mitral cardiac enlargement
and congestive failure
Due to Generalized arteriosclerosis

Duration
Several Yrs

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H F Michel M. D.

Address 2901 Edmondson Date signed Jan 22 46

VS 150

correct age is especially important. Physicians: please write the

G36668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36668 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Pennsylvania Ave
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William De Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Mary Murray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1863

8. AGE: Years: 82 | Months: 7 | Days: 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Valeteriger

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Hines
15. Birthplace Balto, Md.

16 (a) Informant Mary De Ford Murray
(b) Address 1527 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-1946 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lou. M. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 22 1946 (Date rec'd by registrar) (b) [illegible] Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1946, at 1 P. M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skuterelis M.D. Medical Examiner.
Date signed 1-18-46

G36669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G36669
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 254 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 254 Robert St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie D. Reed

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1882

8. AGE: Years 57 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation Teacher & Clerk.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Miss Callie Lytle
(b) Address 1306 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Wm. Chas. H. Appleman
(b) Address 1631 Druid Hill Ave.

19 (a) 1946 (Date rec'd by registrar) (b) Wilmington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Jan 19 1946 and that I last saw h[illegible] alive on Jan 19 1946.

Immediate cause of death — Duration

Due to Intestinal Obstruction 2 hr.

Due to Carcinomatosis

Other Conditions Carcinoma Uteri. Hypertension - Cerebral 3 mos.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 254 Robert St Date signed 1/23/46

VS 150

G36670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77E

Registered No. G36670

Write the causes of death clearly and legibly. Use only black ink. Typewriting preferred. Do not write above or below lines. Be sure that every item is supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Division St
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)
(d) Street No. 1315 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Wilkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/4/11

8. AGE: Years 34 | Months 11 | Days | If less than one day hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lewis Wright
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth Dawson
15. Birthplace N. C.

16 (a) Informant Mrs. Flossie Sawyer
(b) Address 562 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Francis A. Healey
(b) Address 518 W. Baltimore St

19 (a) (Signature of informant) (b) Huntington Williams (Registrar)

JAN 22 1946
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946, at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Alcoholism
Exposure.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Date signed 1-21-46 Medical Examiner.

G36671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36671 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5109 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 Roland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Jarrett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Rebecca Michie
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1888

8. AGE: Years 57 | Months 10 11 | Days 26 | If less than one day 5 hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Ass't Mgr. Crane & Co.
11. Industry or business Plumbing Supplies

FATHER
12. Name Walter J. Jarrett
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Cole
15. Birthplace Va.

16 (a) Informant Mrs. Rebecca M. Jarrett
(b) Address 5109 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1/24/1946 (Date filed with city registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1946, at 6 A, M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to 1/21 1946
and that I last saw h[illegible] alive on 1/21 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 day
Due to: Hypertensive Heart Disease — Duration 9
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack. B. Morgan M. D.
Address 6 E. Read St. Date signed 1/24/46

VS 150

G36672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

Registered No. G36672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 Reisterstown Rd
(c) Hospital or institution: ~
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Ziegler

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Martha B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6 1864

8. AGE: Years 81 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Patapsco Neck

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Charles G. Ziegler
(b) Address 229 Clarendon Ave Govanstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cemetery
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Conrad & Son
(b) Address 2463 Baltimore Street

JAN 22 1946 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1946 at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Jan 20 1946, and that I last saw [illegible] alive on Jan 13 1946

Immediate cause of death
Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward H. Clayton M.D.
Address 511 Cumberland St Date signed

correct age is especially important. Physicians: please write the

VS 150

G36673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3309 Sequoia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1 week

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Sequoia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Barasch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Roumania (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Roumania

MOTHER
14. Maiden Name Not Known
15. Birthplace Roumania

16 (a) Informant Mrs. Edythe Barasch
(b) Address 3309 Sequoia Ave

17 (a) Removal (b) Date thereof 1-22-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New York.
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) JAN 23 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1946, at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1946 to Jan. 22 1946.
and that I last saw him alive on Jan 22 1946.

Immediate cause of death	Duration
Coronary Thrombosis	7 days
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack L. Levin

Address 2322 Fountain Place Date signed 1/22/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58 b

G36674 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 EUTAW PLACE
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-7985

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business International Longshoremans

FATHER
12. Name Not known
13. Birthplace Not known

MOTHER
14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Wife
(b) Address

17 (a) Disposal (Burial, cremation, or removal) (b) Date thereof 1-23-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount Ave

18 (a) Funeral director Jas. E. Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) JAN 23 1946 (b) Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1946, at 9 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1946, to Jan 21 1946, and that I last saw him alive on Jan 21 1946.

Immediate cause of death	Duration
1. Acute myocarditis	
Due to (1) Acute articular Rheumatism	
(2) Acute endocarditis	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles S Nevstadt M.D.
M. D.
Address 1730 Linden Ave Date signed 1/22/46

G36675
AB-96714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G366675
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos- 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie S. Bay

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10-1870

8. AGE: Years	Months	Days	If less than one day
75	8	12	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Kennedy Day
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Endfield
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan 26 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Highland
Location Sharp St, Md.

18 (a) Funeral director Joseph P Harkins
(b) Address Delta, Pa.

19 (a) (b) Huntington Willis M.D.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22- 19 46 at 7.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 19 45 to 1-22 19 46 and that I last saw h or alive on 1-22- 19 46

Immediate cause of death	Duration
Bronchopneumonia	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. P. Jernigan M. D.
Address Baltimore City Hall Date signed 1-23-46

VS 150

G36676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1634 Registered No. G36676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 A. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Everhart Dorothy Everhart

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 23 46 (month) (day) (year)
(c) Cemetery or crematory Rochester New York
Location Rochester New York

18 (a) Funeral director John M. Wilbur
(b) Address 401 S. Chester Street

19 (a) JAN 23 1946 (Date rec'd by registrar) (b) Huntington Wilbur, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17- 1946, at 3:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-17- at A.M.
(b) Where did injury occur? 208 A. Exeter Street
Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas range burner

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 1-17-46

G36677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G36677

Registered No.

EB # 85787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 16
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 W Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Hetterick

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: NINE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1873

8. AGE: Years 72 | Months 0 | Days 19 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam Hettrick
13. Birthplace Germany

MOTHER
14. Maiden Name Dira Popp
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/24/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Fulton Funeral Home
(b) Address 1217 E. Pratt St.

19 (a) JAN 23 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1946, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1946 to Jan. 21, 1946 and that I last saw h. alive on Jan. 21, 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 yrs.

Due to

Due to

Other Conditions: Generalized Arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 1/22/46

(over)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G36678

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N Ellamont St
(c) Hospital or institution:
Feinblatts Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N. Ellamont St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Davidov

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Abraham E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Waski, Lieuthenia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Mayer Faich
13. Birthplace Waski Lieuthenia

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Son - Nathan J Davidov
(b) Address 3218 Eastern Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-46 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd
Location

18 (a) Funeral director Joe Levin and
(b) Address 1434 E. Balto St

19 (a) [illegible] (b) Huntington Williams
(Filed by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-1946, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to 1-22 1946 and that I last saw h[illegible] alive on 1-20 1946

Immediate cause of death Acute Heart Failure — Duration 15 Min

Due to Chr. Myocarditis, Chr. Mitral & Aortic Insufficiency — 4 years ?

Due to Chr. arterio Sclerosis & Hypertension — 4 years ?

Other Conditions — 4 years ?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. Davidov M. D.
Address 3218 Eastern Av Date signed 1-22-46

G36679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

Registered No. G36679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 140 N. Hilton st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 N. Hilton st
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Emma Augusta Thomas.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 7-1857

8. AGE: Years 89 | Months 0 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, County and State)

10. Usual Occupation Ret. School Teacher

11. Industry or business

FATHER
12. Name Charles Thomas.
13. Birthplace England

MOTHER
14. Maiden Name Sophia Ware
15. Birthplace Unknown

16 (a) Informant Mrs. Hugh. Dixon
(b) Address Elm ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Baltimore Md.

18 (a) Funeral director Geo. L. Boyer Jr
(b) Address 1512 Hollins St

19 (a) JAN 23 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to Jan 20 1946, and that I last saw h[illegible] alive on Jan 19 1946

	Duration
Immediate cause of death: Chr Myo cardditis	1 mon
Due to: Generalized Arterio-Sclerosis.	9 yrs.
Due to:	
Other Conditions: Bilateral Cataracts (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Stonecipher M. D.
Address 1 Elmora Ave Date signed 1-21

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

636650 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 East St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Rogers ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife George Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1907

8. AGE: Years	Months	Days	If less than one day
39	-	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Public

FATHER
12. Name George Wilmore
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Minnie Robinson
15. Birthplace Balto. Md.

16 (a) Informant Lottie Wilmore
(b) Address 110 N. East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Cedar Hill, Md

18 (a) Funeral director Holahan Halstead
(b) Address 918 Druid Hill Ave

19 (a) JAN 23 1946 (Date rec'd by registrar) Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946 at 12 30 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to arteriosclerosis

Other Conditions Luetic aortitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Statarelic M.D.
Medical Examiner.
Date signed 1-22-46

VS 151

G36681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 273 N. Exeter St
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 273 N. Exeter
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Austin K. Greene

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife: ?

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 7, 1887

8. AGE: Years 58 | Months 6 | Days 13 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jacob Greene
13. Birthplace Va

MOTHER
14. Maiden Name Julia James
15. Birthplace Va

16 (a) Informant Margret White
(b) Address 273 N. Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-46 (month) (day) (year)

(c) Cemetery or crematory Gallo Nat. Cem
Location Baltimore Md

18 (a) Funeral director Gilligan & Jackson
(b) Address 916 Pennsa ave

JAN 23 1946
(Date rec'd by registrar) Waiting for William

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946, at — M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.

Date signed 1-26-46

VS 151

MAAS ✓

G36682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94R

Registered No. G36682

write the causes of death clearly and legibly. Physicians: please write carefully, important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Cordelia Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Louis O. Maas Sr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-07-4995

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Constance A. Maas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1879

8. AGE: Years 66 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Gettier - Montanye

FATHER
12. Name - Louis O. Maas
13. Birthplace Holland

MOTHER
14. Maiden Name - Bertha Firing
15. Birthplace Norway

16 (a) Informant Mr. Louis O. Maas, Jr.
(b) Address 5001 Cordelia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 23 1946 (Date rec'd by Registrar) (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1946, at 9 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham Medical Examiner. M.D.
Date signed Jan 21 1946

VS 151

G36683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 a

G36683 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Eutaw Place
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILHELMINA HAINES

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Robert T. Haines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1873

8. AGE: Years	Months	Days	If less than one day
73	0	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. H. Straus
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annette Lobe
15. Birthplace Balto., Md.

16. (a) Informant Mr. Henry L. Straus
(b) Address Reisterstown, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Wilson Registrar

JAN 23 1946

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946, at - M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/ 1945, to 1/22/ 1946 and that I last saw h alive on 1/22/ 1946

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to	
Due to Arteriosclerosis	
Other Conditions Pulmonary Oedema	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore H. Morrison M. D.
Address 11 E. Eutaw St Date signed 1/23/46

G366684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 B

G366684 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 119 W. SARATOGA St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Pape

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	10	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Monitor Control Co.

FATHER
12. Name Henry R. Pape
13. Birthplace Ind.

MOTHER
14. Maiden Name Elizabeth Conrad
15. Birthplace Balto., Md.

16 (a) Informant WM. J. TICKNER & SONS
(b) Address Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM. Pape
Location BALTIMORE, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 23 1946 (Date rec'd by registrar) (b) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1946 at 9 A.M. 30

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Comminuted depressed fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-19-46 at 10:30 A.M. 4/6
(b) Where did injury occur? Howard & Saratoga Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Struck by trackless trolley

23. Signature Robert Lee Fratcher M.D. Medical Examiner
Date signed Jan 21 1946

VS 151

636685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

636685 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 223-Jasper Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223-Jasper St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1865

8. AGE: Years 80 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Willis Holland

13. Birthplace Va.

MOTHER 14. Maiden Name Emma B. Queen

15. Birthplace Md.

16 (a) Informant Arthur A. Holland

(b) Address 223-Jasper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location Cedar Hill Md.

18 (a) Funeral director Rudolphus Holland

(b) Address 918-Edmondson Ave.

19 (a) (b) (Signature of local registrar)

JAN 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-1946 at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1946 to Jan. 19 1946 and that I last saw h[illegible] alive on Jan. 19 1946

Immediate cause of death — Duration

(a) Cardiac Vascular — 2 yrs

Due to Senes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

If autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Watts M. D.

Address 5154 Harrington Date signed 1/22/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G36686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 N Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 74 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N Strickers Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ida Burrows

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	col	married

6 (b) Name of husband or wife Thomas Burrows
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1871

8. AGE: Years	Months	Days	If less than one day
74	11	21	hr. min.

9. Birthplace Howard Co Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edward Norris
13. Birthplace Howard Co Md

MOTHER
14. Maiden Name Alice Greene
15. Birthplace Baltimore Co Md

16 (a) Informant Edward Norris
(b) Address 905 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Md

18 (a) Funeral director Wm. D. Kelson
(b) Address 1303 Pressman St

19 (a) JAN 23 1946 (Date received by registrar) (b)

Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1945 to Jan 18 1946, and that I last saw her alive on Jan 18 1946.

	Duration
Immediate cause of death Interstitial Nephritis 18 months two years or longer	2 yrs
Due to Intestinal disturbances for about 18 months	1 year
Due to Idiopathic condition	
Other Conditions Malnutrition three wks	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature L. B. Evans M. D.
Address 426 N. Greene St Date signed 1-22-46

Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use terms of doubtful meaning.

write the causes of death clearly and legibly.

636687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 636687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Pierce St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME James Crawford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	M

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
41 40			..... hr. ..... min.

9. Birthplace Guilford Co. N. C. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant Lillie Bethel
(b) Address Reidsville, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Reidsville
Location Reidsville, N. C.

18 (a) Funeral director Geo. E. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 23 1946 (Date rec'd by registrar) (b) Burial Permit Issued (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946, at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to .....

Other Conditions Coronary sclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Benedict Stomaccio M.D.
Date signed 1-20-46 Medical Examiner.

G36688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G36688 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Rosedale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Rosedale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta T. Kuebler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Fredk H. Kuebler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22 1878

8. AGE: Years	Months	Days	If less than one day
67	10	0	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bernard Kroeger
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa H. Lutman
15. Birthplace Germany

16 (a) Informant Howard I. Kuebler
(b) Address 1411 Rosedale St

17 (a) Burial (b) Date thereof Jan 25 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Henry H. Sherwood
(b) Address 4204 Ridgewood Ave

19 (a) JAN 23 1946 (b) [illegible]
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1946, at 5 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 19— to Present 19—, and that I last saw her alive on Jan. 21 1946

Immediate cause of death	Duration
Coronary Occlusion	Years
Due to Arteriosclerosis	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2924 Brighton St Date signed 1-22-46

G36689

BALTIMORE CITY HEALTH DEPARTMENT

HB #15830 CERTIFICATE OF DEATH 1310

G36689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 6 4
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 145 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Edward Hohlbein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1870

8. AGE: Years 75 Months 1 Days 10 If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Hohlbein
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Germany

16 (a) Informant Balto. City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan 24 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Maurice C Syfer
(b) Address 1600 N Rosedale Ave

19 (a) JAN 23 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1946, at 8:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17, 1934, to Jan. 21, 1946, and that I last saw him alive on Jan. 21, 1946.

Immediate cause of death cardiac failure — Duration

Due to arteriosclerotic heart disease

Due to

Other Conditions cerebral and renal arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address [illegible] Date signed 1/23/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G36690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Ellwood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Ellwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Antkowiak Antkowiak

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 215-09-3243

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida Antkowiak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 60 | Months | Days | If less than one day hr. min.

9. Birthplace Poland. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Antkowiak
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Poland

16 (a) Informant Mrs Ida Antkowiak (wife)
(b) Address 2914 Ellwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 24 46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 401 S. Chester Street

JAN 23 1946 (Date rec'd by local reg'r) Huntington Williams (Signature of local reg'r)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1946 at 6.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 1946, to Jan 20 1946, and that I last saw h-- alive on Jan 20 1946

	Duration
Immediate cause of death: Coronary Thrombosis	5 min
Due to: Arterio Sclerosis	2 yr
Due to: Sen. Arteriosclerosis Nephritis	20
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E E A Stevens M. D.

Address 2818 Harford Rd Date signed 1-22-46

correct age is especially important. Physicians: please write the

VS 150

G36691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & greene
(c) Hospital or institution:
University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Simpsonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Carolyn Marie Bell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1945

8. AGE: Years	Months	Days	If less than one day
—	1 1/2	—	— hr. — min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Joseph Bell
13. Birthplace Md

MOTHER
14. Maiden Name Edna Wood
15. Birthplace Md.

16 (a) Informant Mother
(b) Address above

17 (a) Burial (b) Date thereof 1-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Asbury Md

18 (a) Funeral director F. C. Hyginbotham
(b) Address Ellicott City Md

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1946, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1946, to 1/23 1946, and that I last saw h. alive on 1/22 1946.

Immediate cause of death Pneumonia, Meningitis — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp Date signed 1/23/46

correct age is especially important. Physicians: please write the

VS 150

G36692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36692

1. PLACE OF DEATH: 1713
(a) Baltimore City, Maryland
(b) Street address 1713 Lig Lb St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Lig Lb St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Washburn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.d.

6 (b) Name of husband or wife Margaret McGee

6 (c) If alive, give age (1) years

7. Birth date of deceased (mo., day, yr.) June 19, 1881

8. AGE: Years 64 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name John T. Washburn.
13. Birthplace Balto.

MOTHER
14. Maiden Name Sarah Green
15. Birthplace N.J.

16 (a) Informant Family
(b) Address 1713 Lig Lb St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-25-46 (month) (day) (year)

(c) Cemetery or crematory Pt Covington Md
Location Pt Covington Md

18 (a) Funeral director J. P. McCarthy
(b) Address 1600 E. Fort Ave.

19 (a) JAN 23 1946 (Date rec'd by registrar) Christopher Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21/1946, at 5P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1943 to Jan. 21 1946, and that I last saw him alive on Jan. 21, 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic myocarditis	
Due to	
Other Conditions Senile Malignancy (Untreated),	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. B. Friedman M.D.

Address 1319 Eager St. Date signed 1/24/46

C. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 D

Registered No. G36693

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3120 Gwynn Falls Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

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2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Gwynn Falls Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret R. Babylon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George R. Babylon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1881

8. AGE: Years 64 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John J. Reese
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Elizabeth A. Sharrer
15. Birthplace Westminster, Md.

16 (a) Informant Mrs. Arthur Englar
(b) Address 3104 Ferndale Ave.

17 (a) Burial (b) Date thereof Jan. 24, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18 (a) Funeral director Miller & Lemmon
(b) Address 4510 Liberty Heights Ave.

19 JAN 23 1946 (b)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1946, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1946 to Jan. 22 1946 and that I last saw her alive on Jan. 21 1946

	Duration
Immediate cause of death: Coronary Occlusion	1 day
Due to: Cardio vascular disease	18 mo.
Due to: Arteriosclerosis	?
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence AT M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thaddeus P. Kelbert M. D.
Address 2220 Garrison Blvd. Date signed

VS 150

Jan 23/46

correct age is especially important. Physicians: please write the

G36694

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 45B

Registered No. G36694

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 351 days
(e) Length of stay in Baltimore (yrs., mos., or days) 351 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sullivan, William Franklin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1893

8. AGE: Years 53 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace Oxford, Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name James H. Sullivan
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name Louisa Gibson
15. Birthplace Tilghman's Island, Md.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.24.46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Harry H. Wilkes
(b) Address 410 Edmondson Ave.

19 (d) JAN 23 1946 (Date rec'd by registrar) Livingston Phillips, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1946, at 5:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1945 to Jan. 22 1946, and that I last saw him alive on Jan. 22 1946

	Duration
Immediate cause of death Hemorrhage,	
acute, left neck	10 hrs
Due to Extension of carcinoma	
of tongue	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Too numerous to list
Major findings of operation: 1940-1945
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Wilson
John D. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/22/46
US Marine Hospital, Balto, Md.

G366958732 24

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G36695

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Ringgold

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1907

8. AGE: Years 38 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace Md. - (Town, county, and state)

10. Usual Occupation Chauffeur -

11. Industry or business

FATHER 12. Name Ernest Ringgold

13. Birthplace Md -

MOTHER 14. Maiden Name Belle Matthews

15. Birthplace Md -

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 922 W. Saratoga St.

19 (a) Filed JAN 22 1946 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1946 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945 to Jan. 20 1946 and that I last saw him alive on June 20 1945

Immediate cause of death: Hypertensive cardio-vascular renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip A. Kinnaly

Address Johns Hopkins Hospital Date signed

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G36696

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 1710 Pierce St (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Cora Matthews

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	M

6 (b) Name of husband or wife: Linwood Matthews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-05

8. AGE: Years	Months	Days	If less than one day
40	4 2	5	hr. min.

9. Birthplace Denton Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER

12. Name John Durfin

13. Birthplace Denton Md

MOTHER

14. Maiden Name Cora White

15. Birthplace Denton Md

16 (a) Informant Linwood Matthews

(b) Address 1710 Pierce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 1946 (month) (day), (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 3229 W. Lafayette St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1946, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1946, to 1-18 1946, and that I last saw h-r alive on 1-18 1946.

Immediate cause of death	Duration
Uremia	
Due to Intestinal obstruction	
Due to Abdominal mass ?	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Refused

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Richard Higgins M. D.

Address 2243 Madison Ave Date signed 1-23-46

VS 150

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G36697.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46H

G36697 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution:
Ashburton Nursing Home. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Eutaw Place.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LOEWENBERG.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1862.

8. AGE: Years	Months	Days	If less than one day
83	2		hr. min.

9. Birthplace New York.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adolph Loewenberg.
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Burgunder,
15. Birthplace Germany.

16 (a) Informant Mr. A. Loewenberg,
(b) Address 10 S. Howard St.

17 (a) Burial (b) Date thereof 1.24.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral Chas. Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) JAN 23 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1936 to Jan. 22 1946, and that I last saw h[er] alive on Jan. 22 1946.

Immediate cause of death	Duration
Cardiac renal	
Due to Generalized Sarcomatosis	3 yrs
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Bernard Cohen M. D.
Address Marlborough Apts. Date signed

VS 150

X

G36698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36698 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Miles Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Evans Chapel Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Pfeiffer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-26-8364

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Jane Pfeiffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28-1876

8. AGE: Years 69 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Manchester, Maryland (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business Maryland Casualty Co.

FATHER 12. Name George Pfeiffer

13. Birthplace Maryland

MOTHER 14. Maiden Name Amanda Williams

15. Birthplace Maryland

16 (a) Informant William F. Coburn

(b) Address 4016 Evans Chapel Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24-1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Marie Hampden

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) JAN 23 1946 (Date received by registrar) Huntington Wilson (signature) (b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22- 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1946 to 1/22 1946, and that I last saw h[illegible] alive on 19

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas J. Mercer, M. D.

Address 2020 N. Charles (Date signed)

VS 150

G36699 BALTIMORE CITY HEALTH DEPARTMENT G36699
CERTIFICATE OF DEATH 95 C
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 N Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton A Frazier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Fannie Edwards Frazier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1868

8. AGE: Years 78 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Loading Foreman
11. Industry or business

FATHER 12. Name John L Frazier
13. Birthplace Baltimore

MOTHER 14. Maiden Name Lina -----
15. Birthplace Baltimore

16 (a) Informant Mrs Fred E Wilson
(b) Address 6813 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave E of Gay St

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) JAN 23 1946 (Date received by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1946 5.00PM at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Jan 22 1946, and that I last saw him alive on Jan 15th 1946

Immediate cause of death Heart Insufficiency — Duration couple of years

Due to Hrtens'os Cerous

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Trampff M. D.
Address Lombardy - Hopkins Date signed 1-23-46

VS 150

correct age is especially important. Physicians: please write the

G36700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36700 Registered No.

Typewrite or print in ink; no abbreviations should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 Berry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Berry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Charlotte Ruby.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow.

6 (b) Name of husband or wife Thomas F. Ruby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1867

8. AGE: Years 78 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Nathan Arnold

13. Birthplace Maryland.

MOTHER 14. Maiden Name Julia A. Shipley.

15. Birthplace Maryland.

16 (a) Informant Mrs. Maggie J. Falls

(b) Address 806 Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/46 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Hampden

18 (a) Funeral director Chenowell B. Donovan

(b) Address 3615-17 Chestnut Ave.

19. JAN 23 1946 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1946, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from about Oct. 1945, to 19..., and that I last saw h.r alive on about Dec. 1945

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease	2
Due to Arteriosclerotic cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm N. McFaul Jr. M. D.

Address 840 W. 36th St. Date signed 1/22/46

VS 150

G36701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Cording Ave,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Cording Ave,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles N. McGinnis

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-16-4796

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice V. Hatten
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) June 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	7	4	hr. min.

9. Birthplace Frederick, Maryland.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name William McGinnis
13. Birthplace ?

MOTHER
14. Maiden Name Anna Saumening
15. Birthplace Maryland.

16 (a) Informant Mrs Alice V. McGinnis
(b) Address 506 Cording Ave, Baltimore

17 (a) Burial (b) Date thereof 1/24/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave, Baltimore

18 (a) Funeral director Howard A. Gill
(b) Address 19 W. Pennsylvania Ave, Towson

19 (a) 1/23/1946 (b) Huntington Williams
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1946, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1945 to Jan 21 1946, and that I last saw h.i.m alive on Jan 19 1946

Immediate cause of death Respiratory Failure — Duration 3 days

Due to Cerebral Vascular accident (Rt Lenticulo Striate Artery) — 3 weeks

Due to Hypotension — 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one of place)
(e) Means of injury
23. Signature H. Rackett Donnell M. D.
Address 730 York Rd Balto 4 Date signed 1/24/46

correct age is especially important. Physicians: please write the

G36702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36702 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Glenmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Glenmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise C. Birmingham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
77	10	2		

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles F. Meyers
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Hersh
15. Birthplace Carroll County, Md

16 (a) Informant E. Francis Meyers
(b) Address 3016 Glenmore Ave.

17 (a) Burial (b) Date thereof 1/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director Howard N. Blight
(b) Address 4914 Belair Road

19 (a) JAN 24 1946 (b) Registrar
(Date received by registrar)

Waiting for Information

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1946, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1943 to Jan 21 1946, and that I last saw him alive on Jan 17 1946.

Immediate cause of death Chronic myocarditis — Duration 2 years

Due to

Due to

Other Conditions Arteriosclerosis — 6 years
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify typical place)
(e) Means of injury

23. Signature L. L. Grady M. D.
Address 5106 Harford Rd Date signed 1/22/46

VS 150

G36703

CWK-96666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

138

G36703

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4240 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 26

(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 888 Somerset Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Blackmon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23-1903

8. AGE: Years	Months	Days	If less than one day
42	8	27	hr. min.

9. Birthplace North Carolina

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Elliott Blackmon

13. Birthplace North Carolina

MOTHER

14. Maiden Name Maggie Smith

15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jan. 24-1946

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Md

18 (a) Funeral director Brantmanis & Knight

(b) Address 727 Fairmount Ave

19 (a) JAN 24 1946

(Date of filing)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1946, at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1945 to Jan. 20 1946 and that I last saw h 18 alive on Jan. 20 1946

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions Tuberculous Enteritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Herbert A. Copeland Jr. M. D.

Address Balt. City Hosp Date signed 1/22/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

G36704 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Dukeland St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles T McDermott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Mabel J. McDermott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1st 1882

8. AGE: Years 63 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Own

FATHER
12. Name James McDermott
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Neville
15. Birthplace Unknown

16 (a) Informant Mabel J. McDermott
(b) Address 1407 Dukeland St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/26/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) 1946 (Date) rec'd by registrar (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1946, at 11:55 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Eastman M.D. (Medical Examiner.)
Date signed 1-22-46

G36705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G36705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Logan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14, 1946

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Cottman
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Logan
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 23 1946

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 24 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 19 46 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 14 19 46 to January 15 19 46, and that I last saw her alive on January 15 19 46.

Immediate cause of death: prematurity
? intracranial hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hospital Date signed

VS 180

3219

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36705 BALTIMORE CITY HEALTH DEPARTMENT ✓ G36706

CERTIFICATE OF DEATH 83 2 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 W. Barre
(c) Hospital or institution: 22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 W. Barre
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Eliza Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Alfred Smith
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78	-	—	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Matthew Wesley
13. Birthplace md

MOTHER 14. Maiden Name Nancy
15. Birthplace Md

16 (a) Informant Mildred Garrett
(b) Address 641 W. Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26-46 (month) (day) (year)
(c) Cemetery or crematory
Location Laurel, Ann.

18 (a) Funeral director James A. Hayes
(b) Address 1142 Druid Hill Ave

JAN 24 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1946, at 3.45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1945 to Jan 22 1946 and that I last saw h[illegible] alive on Jan 20 1946.

Immediate cause of death: Cerebral Hemmorhage — Duration 5 days
Due to Uremic Sclerosis — 2 yrs.
Due to Anuria
Other Conditions Prostatic
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Emily Bowley
Address 519 N. Carrollton Date signed 1/23/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36707 ✓ G36707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 543

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2541 E. Monument Street
(c) Hospital or institution: 7-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 E. Monument Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN C. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Gordon Leonard Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1889

8. AGE: Years	Months	Days	If less than one day
56 yrs.	6	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Miller
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Marshall
15. Birthplace Baltimore, Md.

16 (a) Informant Gordon L. Smith (husband)
(b) Address 2541 E. Monument Street

17 (a) Burial (b) Date thereof 1/26/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Moreland Mem. Pk.
Location Raylor Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) 1-27-1946 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 19 , at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1940 to Jan 22 1946 and that I last saw h~~e~~r alive on Jan 22 1946

Immediate cause of death Cerebral Tumor (Cerebellar) with Respiratory Failure — Duration 1 yr 11 days

Due to

Due to

Other Conditions over

(Include pregnancy within 3 months of death)

Date of operation Aug 1, 1945

Major findings of operation Brain Tumor

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury 5

23. Signature Israel Rosen M. D.
Address 2413 E Monument St Date signed 1/23/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(V) G36703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G36703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 Frankstontown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Frankstontown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gabriel J. Bebert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1898

8. AGE: Years 47 | Months | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Stock Clerk

11. Industry or business Grocery Store

FATHER 12. Name Geo J. Bebert
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Martha Baltzel
15. Birthplace Germany

16 (a) Informant Mr. George J. Bebert
(b) Address 601 Frankstontown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4400 Belair Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 2063 Hollins Street

19 (a) 1-24-1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22, 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1941, to 1/22 1946, and that I last saw him alive on 1/21 1946

Immediate cause of death: Carcinoma of Stomach — Duration 2 yrs.

Due to

Due to

Other Conditions 1/2/45

(Include pregnancy within 3 months of death)

Date of operation 12/23/43 & 1/2/45

Major findings of operation: 1st ulcer of stomach 2nd carcinoma of stomach

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1136 Poplar Grove St Date signed 1/23/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

VS 150

G36709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G36709 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Pennsylvania ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Gui Hom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: Yellow

6 (a) Single, married, widowed, or divorced. Married ~~Single~~

6 (b) Name of husband or wife ? Hom (In China)

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace California
(Town, county, and state)

10. Usual Occupation laundry man

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Simon Jung
(b) Address 14 W 21 St - Balto

17 (a) Burial (b) Date thereof 1-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn - Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(Address) (W. F. WOODEN SUC.) 108 N. NORTH AVENUE

JAN 24 1946

19 (a) (Date rec'd by registrar) (b) Huntington W[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 22 - 1946, at 9 37 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1946 to Jan - 22 - 1946, and that I last saw h/ alive on Jan 22 - 1946

Immediate cause of death: Acute Pulmonary Edema — Duration

Due to: Lobar Pneumonia; R.t.b.; R.M.L.; R.U.L.

Due to:

Other Conditions: Arteriosclerotic Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Schlosser M. D.
Address Date signed 1/25/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36710 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN DENZLEIN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaretta Denzlein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1865

8. AGE: Years	Months	Days	If less than one day
80	11	11	hr. min.

9. Birthplace Germany (Town, County, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Germany.

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Sebastian Denzlein
(b) Address 1035 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A.A. County, Md.

18 (a) Funeral director C. Herman Limmer
(b) Address 4611 Park Heights

19 (a) JAN 24 1946 (Must not be filled by registrar) (b) Where was disease contracted if not in place of death?

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 23 1946 at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946; to JAN. 23, 1946, and that I last saw him alive on JAN. 1946.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Exclude pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about ~~home~~, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Schmeisser M. D.
Address 1357 S. Charles Date signed 1/23/46

Hunting for Will. Brother?

G36711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G36711 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 Devenshire Dr
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Devenshire Dr
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country

3 (a) FULL NAME Abraham Joffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Dew
13. Birthplace Russia

MOTHER
14. Maiden Name Dorz
15. Birthplace Russia

16 (a) Informant Lena Joffe
(b) Address 3509 Devenshire Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis & Sne
(b) Address 1459 E. Balto St.

19 (a) JAN 24 1946 (Date received by Registrar) (b) Registrar

Thurlington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-1946, at 10:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 24 1946 and that I last saw him alive on Jan 23 1946.

Immediate cause of death: Pulmonary Oedema — Duration 24 hrs

Due to Aortic Stenosis — Duration months

Due to Arterio-Sclerosis — Duration 4 yrs

Other Conditions Chronic Nephritis — Duration ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Bernard S. Freund, M. D.

Address 2329 Arunah Ave Date signed 1/24/46

VS 150

X

G36713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G36713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Crest Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Crest Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD G. HAYDEN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lola M. Hayden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1880

8. AGE: Years 65 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Queen Anne Co., Md.
(Town, county, and state)
10. Usual Occupation Meat Broker
11. Industry or business

FATHER
12. Name Isaac Hayden
13. Birthplace Del.

MOTHER
14. Maiden Name Elizabeth Duhamel
15. Birthplace Md.

16 (a) Informant Mrs. Lola M. Hayden
(b) Address 2208 Crest Rd.

17 (a) Burial (b) Date thereof 1/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 24 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946, at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1945, to Jan 22 1946, and that I last saw h[illegible] alive on Jan 21 1946.

	Duration
Immediate cause of death: Myocarditis	Indefinite
Due to: Generalized Arteriosclerosis & Diabetes Mellitus.	Indefinite
Due to:	
Other Conditions: Bacterial Asthma. (Include pregnancy within 3 months of death)	10 yrs

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M. Beck M. D.
Address 2727 N. Charles St. Date signed Jan 22 46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

636713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Maine Ave Dot.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Maine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Gardner Uhlenberg

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1884

8. AGE: Years	Months	Days	If less than one day
61	1	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Mangles - Herold Co.

FATHER
12. Name Herman H. Uhlenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Catharine M. Brockhagen
15. Birthplace Germany

16 (a) Informant Mrs. Edward Hoerichs
(b) Address 4506 Maine Ave.

17 (a) Burial (b) Date thereof 1/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 24 1946 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1946, at 12:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Arteriosclerotic C.V. Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sabinske M.D.
Medical Examiner.
Date signed 1/23/46

VS 151

636714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

636714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4646 Pall Mall Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4646 Pall Mall Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Rebecca Williams

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James T. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 1, 1873

8. AGE: Years: 72 | Months: 7 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Sykesville, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Rachel Thompson
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mr. James A. Williams, son
(b) Address: 4646 Pall Mall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/25/46 (month) (day) (year)
(c) Cemetery or crematory: Mountain View Cem.
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 24 194 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22, 1946, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 22 1946 and that I last saw h[illegible] alive on Jan 22 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	24 h
Due to Generalized arterio-Sclerosis	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin E. Mayer M. D.
Address The Esplanade Date signed 1/23/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Edwin E. Mayer

G36715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN W. MINOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Marrried

6 (b) Name of husband or wife Blanche C. Minor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1856

8. AGE: Years	Months	Days	If less than one day
89	11	28 ?	hr. min.

9. Birthplace Warsaw, Va.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Reuben Minor
13. Birthplace Va.

MOTHER
14. Maiden Name Mellissa J. Moody
15. Birthplace Va.

16 (a) Informant Mrs. Burton N. Cox, daughter
(b) Address 1507 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1946, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1945 to Jan. 23 1946 and that I last saw him alive on Jan. 21 1946.

Immediate cause of death	Duration
Myocarditis about	3 mo.
Due to	
Advanced arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Dibble M. D.
Address 2220 Garrison Blvd Date signed 1/24/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100B

636716 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2047 E. Fombud St.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country ?

3 (a) FULL NAME Stephanie Metaja (Mataja)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ? 1879
8. AGE: Years 67 Months Days If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tailoring
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Valerie Rakowska
15. Birthplace Poland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore
18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave
19 (a) (b)
(Date received by Local Registrar)
JAN 24 1946
Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1946, at 7:57 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1946 to Jan 21 1946, and that I last saw her alive on Jan 21 1946.

Immediate cause of death	Duration
Due to Phlebo-Thrombosis	1 day
Due to	
Other conditions Pulmonary Embolism	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos. E. Wheeler
Address South Balto. Gen Hosp. signed 1-24-46 M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36717

AB-98312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83R

Registered No. G36717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Brial

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 1- 1885

8. AGE: Years 60 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Kirkwood (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Augusta (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director J. S. Hilgenstock Son
(b) Address 1300 Eastern Ave.

19 (a) JAN 24 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21- 1946 at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1946 to 1-21- 1946 and that I last saw h- alive on 1-21- 1946

Immediate cause of death Cerebral hem. Acc.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M. Dawson M. D.
Address B.C.H. Date signed 1-21-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G36718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2179 N. Parrish St.
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs+

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2179 N. Parrish
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Pettaway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1913

8. AGE: Years 32 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Tarboro N.C.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER

12. Name Joseph Pettaway

13. Birthplace Tarboro N.C.

14. Maiden Name Milly Powell

15. Birthplace Tarboro N.C.

16 (a) Informant Josephine Taylor

(b) Address 2179 N. Parrish St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan 25 1946 (month) (day) (year)

(c) Cemetery or crematory

Location Tarboro N.C.

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 922 N. Schroeder St.

19 (a) JAN 24 1946 (Date rec'd by registrar) (b) Huntington Williams, Inc. Address

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946, at 7-50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1945 to 1/20 1946 and that I last saw h ev alive on Jan 20 1946

Immediate cause of death Carcinoma of breast — Duration 1 yr

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Redden Jr. M.D.

Address 426 N. Johnson Date signed 1/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G36719

Use cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Mayfield Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John R. Little

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Mary Little
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) March 7- 1899
8. AGE: Years 46 | Months 10 | Days 15 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation.....
11. Industry or business Printer

FATHER
12. Name John R. Little
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mary Lilly
(b) Address 3400 Mayfield Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co
18 (a) Funeral director William Fiaschetti
(b) Address 1618 Eastern Ave
19 (a) JAN 24 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946, at 8 30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation by Carbon monoxide poisoning.
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/22/46 About 7 A. M.
(b) Where did injury occur? 3400 Mayfield Av
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury Turned on gas range open jet

23. Signature Benedict Shiftakelis M.D. Medical Examiner.
Date signed 1-22-46

G36720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95E

Registered No. G36720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Ashland AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-2325

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-03

8. AGE: Years 42 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore md.
(Town, county, and state)

10. Usual Occupation TRUCK DRIVER

11. Industry or business

FATHER
12. Name George Thomas
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name
15. Birthplace Baltimore Md.

16 (a) Informant Susie Holmes
(b) Address 1506 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Md

18 (a) Funeral director Robert F. Williams
(b) Address 15-16 Mc Elderry St

19 (a) (Burial permit issued by registrar) (b) Registrar

JAN 24 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1946, at 8 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Jan. 20 1946, and that I last saw him alive on Jan 20 1946.

Immediate cause of death Congestive Heart failure — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 1-24-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36721 — BALTIMORE CITY HEALTH DEPARTMENT — G36721

CERTIFICATE OF DEATH 1131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3161 Lyndale Avenue
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3161 Lyndale Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh H. Eagan

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-14-1392

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Caroline Frederick
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1862

8. AGE: Years	Months	Days	If less than one day
83	4	26	###### min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Upholsterer
11. Industry or business: Furniture

FATHER
12. Name: Eagan
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Ireland

16 (a) Informant: Mrs. Lee Masmore
(b) Address: 3161 Lyndale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Taylor Avenue, Balto. Co.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) JAN 24 1946 (Date received by Registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946 at 720a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to Jan 22 1946 and that I last saw him alive on Jan 22 1946

Immediate cause of death

Chronic Myocarditis — Duration: wks

Due to

Due to

Other Conditions Contributing to Death but not related to Cause Given Above — Arteriosclerosis — Duration: wks
Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L A Richardson

Address 1710 W. Lafayette Ave Date Jan 22, 1946

936

G36722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 B

G36722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves
(c) Hospital or institution: Levindale Hebrew Home & Infirm.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Blum

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Lehrman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jacob De Baer
13. Birthplace Holland

MOTHER
14. Maiden Name Emma
15. Birthplace Germany

16 (a) Informant Mrs I. Rosenberg
(b) Address 5809 Clover Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 3600 E. Balto st

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave

19 JAN 24 1946 Huntington Williams M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1946, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-76 1945, to 1-23 1946 and that I last saw h[illegible] alive on 1-23 1946.

Immediate cause of death Cerebral Thrombosis — Duration 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund L Kurn M.D.
Address Levindale Date signed 1/25/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G367723 (typed) G367723 (printed) Registered No. 1310

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2607 Loyola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 Loyola Southway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Goldberg

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1866

8. AGE: Years	Months	Days	If less than one day
79	4	21	hr. min.

9. Birthplace Ausria
(Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name
13. Birthplace Austria

MOTHER
14. Maiden Name
15. Birthplace Austria

16 (a) Informant Max Goldberg
(b) Address 2607 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 24 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 12.03

20. DATE OF DEATH January 24 1946 at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to Jan 23 1946, and that I last saw him alive on Jan 23 1946.

Immediate cause of death	Duration
Hypertensive card. vasc. renal syndrome.	
Due to Arterio-sclerosis	
Due to	
Other Conditions Chr. Bronchitis. nasal obstruction.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris G. Ems M. D.
Address 118 Biscuit St. Date signed 1/24/46

G36724 G36724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St Agnes 2D
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brother Robert C.S.C. (JOHN P. TRAINOR)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 15 1858

8. AGE: Years	Months	Days	If less than one day
87	4	7	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Brother (religious)

11. Industry or business

FATHER
12. Name Michael Trainor
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Makan
15. Birthplace Ireland

16 (a) Informant REV. BRO. OSWALD C.F.X.
(b) Address 4409 FREDERICK AVE

17 (a) BURIAL (b) Date thereof 1/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location

18 (a) Funeral Chas J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave

19 Jan 1946 (b) Registrar
(Date received by registrar)

Waiting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1946, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1946, to 1/22 1946, and that I last saw h[im] alive on 1/22 1946.

Immediate cause of death: Pulmonary Embolism — Duration

Due to: Post operative - fall. Surgery pathological section

Due to: Prostate

Other Conditions: Hypertensive CVD

(Include pregnancy within 3 months of death)

Date of operation 1/22/46

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Hope Jr. M. D.
Address Hospital Date signed 1/23/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

X

connect are is especially important. Physicians: please write the ... of information should be carefully supplied. The ... the causes of death clearly and legibly.

G367225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G367225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 Walnut Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Walnut Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6. 1867

8. AGE: Years 79 | Months 0 | Days 16 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation House Duties

11. Industry or business

FATHER
12. Name Julius Rose
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Daffay
15. Birthplace Germany

16 (a) Informant Bernard Rose
(b) Address 705 Walnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25. 1946 (month) (day) (year)
(c) Cemetery or crematory Immanuel Lutheran
Location Irvington Lane

18 (a) Funeral director Mrs. John W. Dentel & Son
(b) Address 801 W. Fayette St.

19 (a) JAN 1946 (Date received by Registrar) (b) Huntington Williams Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22/46 19..., at 8:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John W. Davis M.D.
Medical Examiner.
Date signed 1-23-46

G36726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 5562

G36726 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Sinai Hosp.
(c) Hospital or institution Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 Loyola Southway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA NAN LUTINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1939

8. AGE: Years 6 | Months 7 | Days 11 | If less than one day hr. 2 min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Sidney Lutins
13. Birthplace Balto

MOTHER
14. Maiden Name Lillian Schwartz
15. Birthplace Balto

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pikesville Baltimore Co.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) JAN 24 1946 (Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/46 1946, at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1945 to Jan 24 1946, and that I last saw her alive on Jan 24 1946

	Duration
Immediate cause of death Carcino-neuro-matous failure	
Due to Sarcomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sarcomatosis

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion Rudo M. D.

Address Sinai Hosp. Date signed 1/24/46

X

G36727

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 157E

G36727
Registered No.

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Haissaine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/16/45

8. AGE: Years	Months	Days	If less than one day
	2	7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George J Haissaine
13. Birthplace Balto Md

MOTHER
14. Maiden Name Regina M. Feild
15. Birthplace New Jersey

16 (a) Informant Regina M. Haissaine
(b) Address 1420 W. Pratt St

17 (a) Burial (b) Date thereof Jan 25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Bolt Ct. B.M. Walter

18 (a) Funeral director
(b) Address Pratt & Strickler Sts

19 (a) (b)
(Signature of local registrar) Registrar

JAN 24 1946 Huntington Hillsdale, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 19 46 at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 19 46 to 1/23 19 46 and that I last saw him alive on 1/23 19 46

Immediate cause of death
Cardio-Resp. failure
Due to Congenital abnormal of Heart
Due to
Other Conditions Bronchopneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J. Carroll M.D.
Address St Agnes Hosp Date signed 1/23/46

G36728 G36728

HB # 98718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 N. Calvert St.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME
Harold Critchlow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1900

8. AGE: Years 45 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William J. Critchlow
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Hutzley
15. Birthplace Pa.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-23-46 (month) (day) (year)
(c) Cemetery or crematory Local
Location New Cathedral Cemetery

18 (a) Funeral director W. J. Zeltner & Son
(b) Address 715 Orleans Ave, Balto, Md.

19 (a) JAN 24 1946 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1946 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21, 1946, to Jan. 23, 1946, and that I last saw h 1[illegible] alive on Jan. 23, 1946

Immediate cause of death: Pulmonary Infarct — Duration ?
Cardiac Failure — ?
Due to Rheumatic Heart Disease — ?
Due to Mitral Insufficiency & Stenosis — ?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations: None
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan
Address Baltimore City Hosp. Date signed 1-24-46 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G36729 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave and John St.
(c) Hospital or institution: Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE -13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3619 BREHM'S LANE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS MARIE REBECCA LEONARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife EDWARD T. LEONARD
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1899

8. AGE: Years	Months	Days	If less than one day
46	10	28	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Hsw.
11. Industry or business

FATHER
12. Name GEORGE N. COLE
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name LILLIAN STERLING
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Edward T. Leonard
(b) Address 3619 Brehms Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md

18 (a) Funeral director L. J. Rump
(b) Address 5306 Harford Rd

19 (a) Date received (b) (Registrar)
JAN 24 1946
Huntington Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 January 1946, at 6 40 P.M

21. I certify that death occurred on the date above, that I attended deceased from Oct 1945 to 23 1946, and that I last saw her alive on 22 1946.

Immediate cause of death	Duration
Resp. failure	Jan.
Due to Cerebral embolus	36 hrs.
Due to Rheumatic Heart disease & Mitral & Tricuspid Stenosis	20 yrs
Other Conditions (Abdominal ascites)	

(Include pregnancy within 3 months of death)

Date of operation Post mortem
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Richard Compton M.D.
Address Hosp for Women Date signed 23 Jan. 46

X

G36750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G36750 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Bellona Avenue
(c) Hospital or institution: EDGEWOOD NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Homewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOHN EDWARD Mc CLAINE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna Elliott McCla
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/18/1858

8. AGE: Years	Months	Days	If less than one day
88	0	4	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Boiler Inspector
11. Industry or business: Penna. R.R.

FATHER
12. Name: Levin McClaine
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mr. George T. McClaine
(b) Address: 504 E. 21st. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) JAN 24 1946 (Date received by Registrar) (b) Huntington Mitchell, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1946, at 8.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3, 1946 to Jan. 22, 1946.
and that I last saw him alive on Jan. 21, 1946.

Immediate cause of death	Duration
Uremia	4 days
Due to: Chronic Interstitial Nephritis(unkno	
Due to: ---------	
Other Conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. W. Fitzgerald M.D.
Address 461 E. 25th. St. Date signed 1/23/46.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36731 BALTIMORE CITY HEALTH DEPARTMENT X G36731

CERTIFICATE OF DEATH 1-72

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution U.S. Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Burgaw
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Gleen Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1906

8. AGE: Years 39 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Pender Co., N. C.
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name George Walker
13. Birthplace Pender Co., N. C.

MOTHER
14. Maiden Name Blanche Loftin
15. Birthplace Jones Co., N. C.

16 (a) Informant Mrs. Blanche Loftin Walker
(b) Address Burgaw, N. C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-24-46 (month) (day) (year)
(c) Cemetery or crematory Pike Church Cem. Burgaw
Location Pender Co. N. Carolina

18 (a) Funeral director Wm. J. Tuckan & Sons
(b) Address North Penna Ave

19 (a) Date 1946 (registrar) (b) Huntington Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1946 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Ribs left; bilateral pleurisy with effusion

Due to Fracture of Pelvis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 11 1946
(b) Where did injury occur? S.S. at sea
(c) Did injury occur at home, on farm, industrial place, in public place? Injuring ship at sea While at work? Yes
(d) Means of injury Fell down hatch on ship

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 1-24-46

G36732 BALTIMORE CITY HEALTH DEPARTMENT G36732
CERTIFICATE OF DEATH V 186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35d.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto · 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Ailsa Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Matilda B. Boyd

3 (b) If veteran, name war none
3 (c) Social Security Account No. none
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife John Boyd
(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 17, 1862
8. AGE: Years 83 Months 5 Days 7 If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Gilmore
13. Birthplace Ireland

MOTHER
14. Maiden Name Matilda McElroy
15. Birthplace Ireland

16 (a) Informant Mrs. Wm F. Schmid
(b) Address 3311 Ailsa Ave Balto

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/24/46 (month) (day) (year)
(c) Cemetery or crematory Arlington Cem
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tichenor & Sons
(b) Address Balto. Md.

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1946, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1946 to 1-24 1946, and that I last saw her alive on 1-24 1946

Immediate cause of death Cardiac Failure — Duration

Due to Senility

Due to

Other Conditions Fract. Femur Rt. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/3
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Dec. 10, 1945 M
(c) Where did injury occur? 3311 Ailsa Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped and fell to floor
23. Signature Chas. Shaklan M. D.
Address Mercy Hosp Date signed 1-24-46

Howard J. Madeira, M.D. X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

VS 150

G36733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G36733

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution N. Calvert St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7738 Evergreen Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lois J. Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-45

8. AGE: Years	Months	Days	If less than one day
0	9	2	— hr. — min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Charles O. Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Joyce Odom
15. Birthplace Tennessee

16 (a) Informant Mother
(b) Address 7738 Evergreen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25 '46 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Fredk. ave

18 (a) Funeral director John O. Gerstell & Sons
(b) Address 1400 E. Eutaw Place, Balto, Md

19 (a) 10-5-0 (Registered by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1946 at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1946, to 1-23 1946, and that I last saw her alive on 1-23 1946.

Immediate cause of death	Duration
Acute Cardiac failure	½ hour
Due to Extreme acidosis and dehydration	3 days 1 week
Due to Diarrhea	1 day
Other Conditions Probable bronchopneumonia left base (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph E. Read M. D.
Address Mercy Hospital Date signed 1-23-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Name of informant should be carefully supplied. The

VS 150

G36734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G36734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Belmar Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Belmar Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma G Lastner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: J Edward Lastner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 10 1881

8. AGE: Years 64 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry Herpich
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jane Mencken
15. Birthplace Baltimore Md

16 (a) Informant J Edward Lastner
(b) Address 4203 Belmar Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Loeacher Funeral Home
(b) Address 7401 Belair Road

19 (a) JAN 24 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1946 at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to Jan 22 1946 and that I last saw h[illegible] alive on Jan 22 1946

Immediate cause of death: Cardiac Arrest — Duration: 1 day

Due to: Pneumonia Lobar — 1 yr.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L F Hoffman M. D.
Address 116 Randall St Date signed 1/24/46

correct age is especially important. Physicians: please write the

VS 150

G36735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36735 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Linnard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Linnard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Little

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maggie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1867

8. AGE: Years 78 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace England
(town, county, and state)

10. Usual Occupation Clerk

11. Industry or business R.R.

FATHER
12. Name John Little
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Maggie I. Little
(b) Address 609 Linnard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/46
(month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Co Inc

(b) Address 1217 E Cold St

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1946 at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1942 to Jan 23 1946 and that I last saw h alive on Jan 22 1946

Immediate cause of death
Pneumonia — Duration 8 days

Due to Chronic Interstitial Nephritis — 3 yrs Chronic

Due to General Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(c) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Druid Pk Date Signed

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36736

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Type

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143 Paloma Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 Paloma Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband/wife~~ wife Alice Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9th 1861

8. AGE: Years	Months	Days	If less than one day
84	4	14	hr. min.

9. Birthplace Balto. Md.
(Town, county and state)
10. Usual Occupation Retired
11. Industry or business Machinist

FATHER
12. Name Warner Thomas
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Liza Barry
15. Birthplace Balto. Md.

16 (a) Informant Alice Wagner
(b) Address 43 Paloma Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/26/46 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23rd 1946, at 6:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Jan 23 1946 and that I last saw ~~him/her~~ alive on Jan 21 1946

Immediate cause of death
Coronary Thrombosis — Duration 3 hours
Due to Cardio-Vascular Disease — 2 years
Due to
Other Conditions Morbid Arteriosclerosis — Unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Fredericks Ave Date signed

VS 150

G36737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36737 Registered No.

Please write or print information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Forbes + 31st St
(c) Hospital or institution: The Homewood Apts
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Forbes + 31st St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth L Cockrill

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Dr Joseph M Cockrill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1853

8. AGE: Years 92 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Robert Read
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Ellen Merritt
15. Birthplace Baltimore Md

16 (a) Informant Elizabeth C Thomas
(b) Address 45 W 29th St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Tillman Love Inc
(b) Address 1217 E Fort Ave

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1946, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Jan 23 1946, and that I last saw h[illegible] alive on Jan 23 1946

	Duration
Immediate cause of death: Cardio vascular lesion	1 wk
Due to: Arterio sclerosis + senility	7 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Beuman and Hood MD
Address 2200 Garrison Blvd Date signed 1/24/46

VS 150

G36738 G36738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V162B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 741 W. Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Thompson (alias Roy Welch)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1907

8. AGE: Years	Months	Days	If less than one day
39	8	-	hr. min.

9. Birthplace Floyd Co Va
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Will Thompson
13. Birthplace Floyd County Va.

MOTHER
14. Maiden Name Almeda DeHelon
15. Birthplace Floyd County Va

16 (a) Informant Mrs. Edmund Abell
(b) Address Roanoke Va

17 (a) Removal (b) Date thereof 1/24/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Floyd Co
Location Floyd Co Va

18 (a) Funeral director Williams Cook Co
(b) Address 1217 E Cary St

19 (a) JAN 24 1946 (b)
(Local Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1946, at 9:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Phenol poisoning

Due to Ingestion of Phenol

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 20, 1946 M.
(b) Where did injury occur? 741 W. Franklin
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Ingestion of phenol

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed 1-21-46

G36739 BALTIMORE CITY HEALTH DEPARTMENT ✓ G36739
CERTIFICATE OF DEATH 83a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Wayne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Wayne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph William Broome

3 (b) If veteran, name war
3 (c) Social Security Account No. 705-10-4550

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gertrude Broome
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 11, 1890

8. AGE: Years 55 | Months 6 5 | Days 12 | If less than one day hr. min.

9. Birthplace Brooklyn, N. Y. (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Western Md. Railway Co.

FATHER
12. Name Jacob Henry Broome
13. Birthplace Brooklyn, N. Y.

MOTHER
14. Maiden Name Lillian E. Tarrant
15. Birthplace Brooklyn, N. Y.

16 (a) Informant Mrs. Gertrude Broome
(b) Address 3016 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Limoges
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946, at 1A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on 1-22-1946

Immediate cause of death Cerebral Hemorrhage — Duration ?
Due to
Due to See other side
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harper M. D.
Address 5201 Gwynn Oak Ave. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... carefully supplied. The

VS 150

X

G36740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G36740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution University Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Hilton st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Warns (Margaret D.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1946

8. AGE: Years — Months — Days 16 If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis W. Warns
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Evelyn J. Callender
15. Birthplace Balto. Md.

16 (a) Informant Louis W. Warns
(b) Address 6 N. Hilton St.

17 (a) Burial (b) Date thereof 1/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) JAN 25 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-46 1946, at 7:40 ~~A.M.~~ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1946, to 1-23 1946 and that I last saw h alive on 1-23 1946

Immediate cause of death Premature — Duration

Due to Infectious Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Drake M. D.
Address Union Mem. Hos. Date signed 1-24-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G36741 Registered No.

CHK-98578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 E. Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Neal

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Edward Neal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10-1869

8. AGE: Years 76 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hiram Corliss
13. Birthplace Conn.

MOTHER
14. Maiden Name Lucretia Turner
15. Birthplace Md.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 1/26/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 S. Paul St

JAN 25 1946 (Date rec'd by Registrar) (By the authority of) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1946, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1946 to Jan. 23 1946 and that I last saw h er alive on Jan. 15 1946

Immediate cause of death: cardiac failure — Duration

Due to: Hypertension arteriosclerosis

Due to:

Other Conditions: Wasting and pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.

Address 1 E 86 Date signed 1/24/46

To be approved by Medical Examiner.

VS 150

correct age is especially important. Physicians: please write the

G36742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TH. 87782

Registered No. G36742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-8-19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Chesapeake Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Glodeck (Glodek)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Edward
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 27th 1919
8. AGE: Years 25 Months 3 Days 26 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Edward Teal
13. Birthplace Maryland
MOTHER 14. Maiden Name Vernita Schaeffer
15. Birthplace Maryland
16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location AA Co.
18 (a) Funeral director George A Weber
(b) Address 705 S Pine st
JAN 25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23rd 1946, at 5.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4th 1944 to Jan. 23 1946 and that I last saw h or alive on Jan. 23 1946

Immediate cause of death: Pulmonary Tuberculosis Bilateral — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B & K Date signed 1/23/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1240

G36743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State SC (b) County
(c) City or town Pendleton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 168
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Massingill, Douglas Frederick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1911

8. AGE: Years 34 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace West Union, SC.
(Town, county, and state)

10. Usual Occupation 2nd Asst. Eng.

11. Industry or business seafarer

FATHER
12. Name James Max Massingill
13. Birthplace Ricker, SC

MOTHER
14. Maiden Name Margaret Shockley
15. Birthplace West Union, SC

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25 46 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cemetery
Location York Rd.

18 (a) Funeral director Odea Funeral Home Inc.
(b) Address 4644 York Rd.

19 (a) Registrar's signature (b) Hunter for Williams
JAN 25 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1946, at 3:47P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1946, to Jan. 22 1946, and that I last saw h im alive on Jan. 22 1946.

	Duration
Immediate cause of death Uremia	4 days
Due to Portal cirrhosis, Laennec's cirrhosis	10 days
Due to Diffuse degeneration of liver hepatitis due to poison	10 days
Other Conditions Due to Bile nephrosis and anuria	10 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 1/24/46 D.
US Marine Hospital, Balto, Md.

correct age is especially important. Physicians: please write the

VS 150

G36744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G36744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1737 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: PHILLIE MUFFOLETTO

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Samuel Muffoletto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1901

8. AGE: Years 44 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Cerrito
13. Birthplace: Italy

MOTHER
14. Maiden Name: Josephine Gugliuzza
15. Birthplace: Italy

16 (a) Informant: Mr. Samuel Muffoletto
(b) Address: 1737 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 25 1946 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1946, at 4P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22, 1945 to Jan. 22, 1946, and that I last saw her alive on Jan. 22, 1946.

Immediate cause of death	Duration
Carcinoma - intestines and liver	
Due to	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene P. Cassagne M. D.
Address 514 DRURY LANE Date signed 1/27/46

correct age is especially important. Physicians: please write the

VS 150

G36745 ✓ G36745

BALTIMORE CITY HEALTH DEPARTMENT

TN. 98333 **CERTIFICATE OF DEATH** 160a Registered No. (Grey)

Type or print in ink. Every question must be answered. If information cannot be obtained, write UNKNOWN. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 18 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15½ Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 W. Hollin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Bryant (Dora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6th 1946

8. AGE: Years | Months | Days | If less than one day: 15 ½ hrs hr. mn.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Stewart Bryant
13. Birthplace Va.

MOTHER — 14. Maiden Name Dora Ramsey
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (records

17 (a) [redacted], cremation, [redacted] (b) Date thereof 1-23-46 3.00 P M at
(month) (day) (year)
(c) [redacted] or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director Baltimore City Hospitals
(b) Address (Records

19 (a) JAN 25 1946 (b) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6th 1946 at 3.07 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6th 1946 to Jan. 6 1946 and that I last saw h[redacted]er alive on Jan. 6th 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Prematurity (34-36 wks)	
Gestation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-6-46
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Gauthier, M. D.
Address B C H. Date signed 1-11-46

VS 150

X

G36746 BALTIMORE CITY HEALTH DEPARTMENT X V G36746

CERTIFICATE OF DEATH 83B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 + Calvert
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Emily Boyce Mackubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1876

8. AGE: Years	Months	Days	If less than one day
69 64	10	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Mackubin
13. Birthplace Maryland

MOTHER
14. Maiden Name Gabriella Peter
15. Birthplace Washington D C

16 (a) Informant Ella Mackubin
(b) Address Ellicott City Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-28-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F.C. Higinbotham
(b) Address Ellicott City Md

19 (a) JAN 25 1946 (b)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1946, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1945 to Jan 25 1946, and that I last saw h[illegible] alive on Jan 25 1946.

Immediate cause of death Cerebral Thrombosis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee III

Address Union Memorial Hospital Date signed 1/26/46

Huntington Williams M.D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G36747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 N. Bond Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FRANCES ELIZABETH MORRIS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ralph Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1860

8. AGE: Years 85 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Reidsville, Ga. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Sharp
13. Birthplace Georgia

MOTHER
14. Maiden Name Emily Brasswell
15. Birthplace Georgia

16 (a) Informant Thomas G. Williams
(b) Address 1827 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- -1943 (month) (day) (year)
(c) Cemetery or crematory Reidsville Cemetery
Location Reidsville, Ga.

18 (a) Funeral director HENRY SANDER & SONS, INS.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 25 1944

VS 150

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH Jan. 24 1946, at 8.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11- 1945, to Jan 24 1946, and that I last saw h.. alive on Jan 23d 1946.

Immediate cause of death — Duration

Edema Lungs — 1 days
Due to
Chronic Myocarditis — 8 yrs
Due to
Other Conditions Arterio-Sclerosis — 10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North Ave Date signed 1/24/46 M. D.

correct age is especially important. Physicians: please write the

X

G36748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G36748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MIDA CORNELIA CORPREW

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1862

8. AGE: Years 83 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas Corprew
13. Birthplace Virginia

MOTHER
14. Maiden Name Luranah Corprew
15. Birthplace Not known

16 (a) Informant John M. Lewis
(b) Address 2811 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26,46 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEMETERY
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

JAN 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1946, at 11:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1939 to Jan 24 1946 and that I last saw h[illegible] alive on Jan 24 1946

Immediate cause of death: Pneumonia — Duration 7 yrs

Due to

Due to

Other Conditions: Cerebral Hemorrhage — Duration 1 wk

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Richardson MD

Address 1120 N. Eden St Date signed Jan. 24, 46

correct age is especially important. Physicians: please write the

JVS 150

G36749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36749

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. University Pky.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs. 3 mos. 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pkwy.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Amélie de Pau Fowler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1859

8. AGE: Years 86 | Months 3 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Patterson, N. J.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name de Grasse B. Fowler
13. Birthplace N. Y. State

MOTHER
14. Maiden Name Julia K. Colt
15. Birthplace Baltimore

16 (a) Informant Miss Alice Fowler
(b) Address 100 W. University Pkwy

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Lawn
Location Paterson, N. J.

18 (a) Funeral director Henry H. Kaltenbach Sons
(b) Address 111 N. Eutaw St.

19 (a) (Date) (b) Registrar
Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1946, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to Jan 24 1946, and that I last saw her alive on Jan. 24 1946

Immediate cause of death	Duration
Hypertensive cardio-vascular disease. Cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charlotte McCarthy M. D.
Address 618 Medical Arts Bldg. Date signed Jan 25 '46

VS 150

636750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 636750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 E Preston St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Over 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 E Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Emory Lord
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Charles Edord
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/1867

8. AGE: Years 78 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Hartford Cty - Md
(town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Thomas Lane Emory
13. Birthplace Mayer Ldr - Harford Co - Md.

MOTHER
14. Maiden Name Priselda Holmes
15. Birthplace Baltimore Md.

16 (a) Informant A. Worrell - (Granddaughter)
(b) Address 22 E. Preston St Balto - Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/26/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Cty. Balto Md

18 (a) Funeral director Henry W. Perkins & Sons Co
(b) Address Orchard & McCulloh Sts -

19 (a) JAN 25 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1946, at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1946 to 1/23 1946, and that I last saw h[illegible] alive on 1/22 1946

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to ✓

Due to ✓

Other Conditions Gall Bladder Disease

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation: ✓

of autopsy: ✓

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature Chas F Blake M. D.
Address 20 E Preston Date signed 1/25/46

X

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. 6804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hampton Court Apts. Wolfpheia St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Irving Adams

3 (b) If veteran, name war Spanish american

3 (c) Social Security Account No. 217-01-2407

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Sidney R. Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 30 1878

8. AGE: Years	Months	Days	If less than one day
67	8	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Coal business
11. Industry or business

FATHER
12. Name Orson Adams
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie L. Fisher
15. Birthplace Baltimore

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Jan 26 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Balto Md

18 (a) Funeral director Henry W. Jaspins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) **(b)** Huntington Williams Registrar

JAN 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946, at 1 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1946 to Jan. 24 1946, and that I last saw h[illegible] alive on Jan 24 1946.

Immediate cause of death	Duration
myocardial infarction	
Due to arteriosclerotic cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, 3rd
Address Union Memorial Hospital Date signed 1/26/46 M. D.

J. Frank Supplee - 3rd

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 50

Registered No. G36752

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 N.Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 N.Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith C.Berger

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Earnest C.Berger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.25-1867

8. AGE: Years	Months	Days	If less than one day
78	2 3	2 27	hr. min.

9. Birthplace Not Known (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Collier
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Carrie Berger
(b) Address 1300 N.Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.25/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville,Md.

18 (a) Funeral director John A .Miller
(b) Address 2334 Jefferson St.

19 (a) JAN 25 1946 (Date received by registrar) (b) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1946, at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946, to 1/22 1946, and that I last saw h. alive on 1/22 1946.

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Generalized Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury 2

23. Signature J. B. Bellina M. D.
Address 1036 - N. Calvert Date signed 1/24/46

VS 150

G36753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G36753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Lanvale
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Moore House.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown Winer Moore
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown Bettie McKay
15. Birthplace S. C.

16 (a) Informant Chas Thrower
(b) Address 824-N. Stricker St.

17 (a) Burial (b) Date thereof 1-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Hertis Hill Ave.

19 (a) Registered (b) Hunter for Williams, M.D.
JAN 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1946, at 2.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1946, to Jan 20 1946, and that I last saw her alive on Jan 20 1946

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. Howell M. D.
Address 601 W. Lanvale St. Date signed 1/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G36754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town [redacted] Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Hartford Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Rosling

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/45

8. AGE: Years	Months	Days	If less than one day
—	1 mo	-	— hr. — min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name John C. Rosling
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name Virginia Mechino
15. Birthplace North East, Md.

16 (a) Informant Mother
(b) Address above

17 (a) Burial (b) Date thereof 1-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morelands Mem.
Location Taylor Ave.
18 (a) Funeral director John F. Connelly
(b) Address Essex, Md.
19 (a) (b)
(Date rec'd by registrar) Huntington Williams M.D.

JAN 25 1946

W 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1946, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1946, to 1/22 1946, and that I last saw h[illegible] alive on 1/22 1946.

Immediate cause of death Prematurity — Duration —

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Univ. Hosp. Date signed 1/23/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

Registered No. G36735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4309 Reisterstown Road
(c) Hospital or institution: Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 13
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4309 Reisterstown Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth L.Cannon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Franklin P. Cannon
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) March 10, 1869

8. AGE: Years 76 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Northumberland Co., Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Isabel Hayden
15. Birthplace Virginia

16 (a) Informant Roland I. Cannon
(b) Address 4309 Reisterstown Road,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/46 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Cemy.
Location Cambridge, Md.

18 (a) Funeral director John O. Mitchell Fun. Dir.
(b) Address 1900 Eutaw St.

19 (a) (b)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1946 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-23 1945 to Jan 24 1946 and that I last saw h[illegible] alive on Jan 24 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: abt 3 hrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Bulert, M. D.
Address 4803 Park Heights Ave Date signed 1/24/46

correct age is especially important. Physicians: please write the

VS 150

G367756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No. G367756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 4206 Roland Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Roland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ELEANORA R. STIEGLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1865

8. AGE: Years	Months	Days	If less than one day
81	0	13	hr. min.

9. Birthplace Fallston, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Stiegler
13. Birthplace Bavaria, Germany

MOTHER
14. Maiden Name Eleanora Fischer
15. Birthplace Hanover, Germany

16 (a) Informant Mrs. Anna Stiegler
(b) Address 4206 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 25 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Jan. 22, 1946, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1946, to 1/22 1946
and that I last saw her alive on 1/21 1946.

Immediate cause of death: Cerebral thrombosis — Duration 3 hrs
Due to: Cerebral arteriosclerosis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry A. McGarity M. D.
Address 37 W Preston St Date signed 1/25/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered G36757

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HENRY BURROWS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Burrows
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1875

8. AGE: Years	Months	Days	If less than one day
70	5	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Market
11. Industry or business Self

FATHER
12. Name Joseph Burrows
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Burrows
15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Margaret Burrows
(b) Address 818 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 25 1946 (Date rec'd by registrar) (Signature) Thomas J. Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 23, 1946 at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to 1/23 1946 and that I last saw h[illegible] alive on 1/22 1946.

Immediate cause of death	Duration
Myocardial degeneration	4 yrs
Due to Chr. nephritis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer C. Todd M. D.
Address 2508 St Paul St Date signed 1/24/46

G36758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. G36758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LOMBARD & GREENE STS.
(c) Hospital or institution: UNIVERSITY HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Linden Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME GLORIA WORTH (WIRTH)

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-2527

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: James M. Wirth
(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 31, 1918

8. AGE: Years 27 | Months 8 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Cleveland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Eckman
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr. James M. Wirth
(b) Address 704 N. Linwood Ave

17 (a) Burial (b) Date thereof Jan 26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Lawn
Location Gallows

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St

19 (a) JAN 25 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1946, at 4:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1946 to 1-24 1946, and that I last saw her alive on 1-24 1946

	Duration
Immediate cause of death: CARDIAC FAILURE	1 hr.
Due to: HEPATIC FAILURE	
Due to: CHOLANGIOTIS	10 days
Other Conditions: PREGNANCY	7 mo.

(Include pregnancy within 3 months of death)

Major findings:
Of operation: CHOLANGITIS SUPP., SL. THICKENED GALL BLADDER
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene H. Cowan M.D.

Address Univ. Hosp. Date signed 1-24

Write the causes of death clearly and legibly. Physicians: please write the words "Baltimore City" in the space for "Place of Death" and be especially careful to write the correct street address.

636759

BALTIMORE CITY HEALTH DEPARTMENT 136

CERTIFICATE OF DEATH 236

Registration No. 636759

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 N. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 N. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nellie Spearman ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Offie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1902

8. AGE: Years 43 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Fayetteville N. Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Moses McClean

13. Birthplace N. C.

MOTHER 14. Maiden Name Cora ?

15. Birthplace N. C.

16 (a) Informant Effie Spearman

(b) Address 1005 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location G. A. County

18 (a) Funeral director Mrs. Robert G. Ellison Jr.

(b) Address 1399 N. Carolina St.

19 (a) JAN 25 1946 (Date rec'd by registrar) (b) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1946, at 5.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1946 to 1-21 1946 and that I last saw h[illegible] alive on 1-21 1946.

	Duration
Immediate cause of death: Acute myocarditis	1 Day
Due to: Lobar Pneumonia	7 Days
Due to: La Grippe	2 Days

Other Conditions (over)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry M. D.

Address 1420 E. Chase St Date signed Jan 25 46

VS 150

1420 E. Chase St X

G36760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36760
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Pochroe Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Strauss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Goldi
15. Birthplace Russia

16 (a) Informant Max Strauss
(b) Address 716 Second Ave N.W. Wash

17 (a) Burial (b) Date thereof 1-27-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Adat Shalom
Location Washington D.C.

18 (a) Funeral director JACK LEWIS Inc
(b) Address 2100 EUTAW PLACE

19 (c) JAN 25 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1946 at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1946 to 1-24 1946, and that I last saw her alive on 1-14 1946.

	Duration
Immediate cause of death Arteriosclerotic Heart Disease & Hyp. Heart Disease	10 years
Due to Peripheral embolism	3
Due to Gangrene of both legs	5 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Randall Pate M. D.
Address Sinai Hosp Date signed 1-24-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

correct age is especially important. Physicians: please write the

G36761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G36761
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Whatcoat St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No 1104 Whatcoat St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mazie Bertha Wright

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	D

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/15

8. AGE: Years	Months	Days	If less than one day
30	7	1	hr. min.

9. Birthplace Md
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Marion Harper
13. Birthplace Md

MOTHER
14. Maiden Name Mamie Wright
15. Birthplace Md

16 (a) Informant Mamie Wright
(b) Address 1844 Penna Ave

17 (a) Burial (b) Date thereof 1/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Wm. B. Kelson
(b) Address 1303 Pressman St

19 (a) (b)
(Date received by Registrar) Registrar

JAN 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 46, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 46, to 1/23 46, and that I last saw h — alive on 1/23 1946.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 734 W Mt Royal Ave Date signed 1/24

G367652

BALTIMORE CITY HEALTH DEPARTMENT ✓ G367652

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Smithson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Bea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	(Single) Married

6 (b) Name of husband or wife (Sandie) Bea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/1904

8. AGE: Years	Months	Days	If less than one day
41	11	7	hr. min.

9. Birthplace Northumberland Co. Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Willis Bea
13. Birthplace Northumberland Co. Va

MOTHER
14. Maiden Name Fannie Blackwell
15. Birthplace Northumberland Co. Va

16 (a) Informant Sandie Bea
(b) Address 1322 Smithson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Ged. B. Kelson
(b) Address 1303 Reisterstown Rd

19 (a) (b) Williamsport Md.

JAN 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1946, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1946, to 1-22 1946 and that I last saw h.m. alive on 1-22 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to undetermined	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury?
23. Signature Marlyn J. Wantz M. D.
Address 861 Hanlon Date signed 1/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36763 BALTIMORE CITY HEALTH DEPARTMENT G36763
CERTIFICATE OF DEATH
Registered No. 1700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D 0 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Clinton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hattie Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ~~Wife~~ WIDOW

6 (b) Name of husband or wife Richard Wilkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 - 1878

8. AGE: Years 68 | Months - | Days 14 | If less than one day hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation National Brewing Co

11. Industry or business

FATHER 12. Name Robert Weichert
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Herbert Brown
(b) Address 16 N. ~~Clinton~~ Gilmor St.

17 (a) Burial (b) Date thereof 1-28-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. L. Rauch
(b) Address 500 N. Gilmor St

19 (a) Filed ~~1-25-1946~~ (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946, at 7:45 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 25 1946 4/1 M.
(b) Where did injury occur? Park Ave. & Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury struck by truck

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1-25-46

VS 151

G36764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77C

Registered No. G36764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp - 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D's -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 E. 28th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 - 1888

8. AGE: Years 57 | Months 6 7 | Days 8 | If less than one day hr. min.

9. Birthplace Harford Co - Md. (Town, county, and state)

10. Usual Occupation carpenter

11. Industry or business

FATHER
12. Name Dennis A. Bradley
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Dennis
15. Birthplace Md.

16 (a) Informant Mrs. Sarah Martin
(b) Address 4216 Clayton Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-46 (month) (day) (year)
(c) Cemetery or crematory Bals National
Location Baltimore

18 (a) Funeral director Leonard J. Huck
(b) Address 5315 Harford Road

19 (a) JAN 25 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1946, at 8:35 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions Pulmonary Emphysema, Marked

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert C. Graham M.D. Medical Examiner.
Date signed 1-27-46

VS 151

Please write the causes of death clearly and legibly. Physicians, undertakers, and registrars: Please write the causes of death clearly and legibly.

G36765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G36765 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Bayonne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Bayonne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Frank Wurzbacher

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-5517

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Amanda L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 1882

8. AGE: Years	Months	Days	If less than one day
63	3	17	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Md. Trust Co.

FATHER
12. Name Adolph H. Wurzbacher
13. Birthplace Md.

MOTHER
14. Maiden Name Anna M. Green
15. Birthplace Md

16 (a) Informant Mrs Amanda L. Wurzbacher
(b) Address 3012 Bayonne Ave.

17 (a) Burial (b) Date thereof 1- -46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1946, at 2 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1940 to Jan 23 1946 and that I last saw h alive on Dec 20 1945.

Immediate cause of death	Duration
Coronary Occlusion	10 minutes
Due to Arteriosclerosis	6 years
Due to	
Other Conditions Cerebral Hemorrhage	Jan 23

(Include pregnancy within 3 months of death)
Date of operation None 1940
Major findings of operation Cholelithiasis
of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature L. L. Goodz M.D.
Address 5706 Harford Rd Date signed 1/27/46

Howard J. Mesereis, M.D.

VS-150

correct age is especially important. Physicians: please write the

G36766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B ✓

G36766 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital 61
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No. 716-01-9186

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/85

8. AGE: Years	Months	Days	If less than one day
61	-	13	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Penn. R. R.

FATHER
12. Name Henry Hudson
13. Birthplace England.

MOTHER
14. Maiden Name Catherine Burke
15. Birthplace Ireland

16 (a) Informant Catherine Hudson
(b) Address 231 N. Fremont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory New Cath.
Location Old Frederick Rd.

18 (a) Funeral director Jos. A. Hagan
(b) Address 3600 E. Baltimore St.

19 (a) JAN 25 1946 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23/46 19.., at 11:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2-3 19 46 to 1/2-3 19 46, and that I last saw him alive on 1/2-3 19 46.

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Coronary Occlusion	
Due to	
Other Conditions Hypertheroidism	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Emphysema; Myocardial Damage.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H. Frank M. D.
Address 1. Jas. Hosp. Date signed 1-27-46.

944

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G36767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G36777 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Denver St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 66yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Denver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F. Shamleffer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1879

8. AGE: Years 66 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore - Md (Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George H. Shamleffer
13. Birthplace Reisterstown Md

MOTHER
14. Maiden Name Ellen Smith
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Grace Michaels
(b) Address 2315 Cedley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26 1946 (month), (day), (year)
(c) Cemetery or crematory St. Pauls
Location Baltimore - Md

18 (a) Funeral director Leonard L. Covington
(b) Address 21 W. 20th St.

JAN 25 1946 (Date rec'd by registrar) (b) Thomas J. Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1945 to 1/24 1946.
and that I last saw him alive on 1/23 1946.

Immediate cause of death Hemiplegia

Due to

Due to Arteriosclerosis C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
10 days
5 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Williams M.D.
Address 201 Ampelia Date signed 1/25/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36768 ✓ G36768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92C

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 Mura St.
(c) Hospital or institution:

8-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Mura St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Wilkins

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Minnie Wilkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1875

8. AGE: Years	Months	Days	If less than one day
70	11	0	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant William Appler.
(b) Address 2218 Mura St

17 (a) Burial (b) Date thereof Jan 26, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto, Md.

18 (a) Funeral director Durward L. Carrington
(b) Address 21 W. 25th St.

19 (a) (b)
(Date rec'd by registrar) (Signature of registrar)

JAN 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Jan 23 1946 and that I last saw him alive on Jan 21 1946.

Immediate cause of death Arteriosclerosis — Duration 5 Years

Due to Arteriosclerosis — 5 yrs

Due to Renal Insufficiency — 10 yrs.

Due to Hypertension — 10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 9858 Harford Rd Date signed 1/28/46

Please print the cause of death clearly and legibly.

G36709 ✓ G36709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 911 Argyle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 23 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Red Cap

11. Industry or business

FATHER
12. Name George W. Cook
13. Birthplace Catonsville Md

MOTHER
14. Maiden Name Effa Jones
15. Birthplace Balto. Md

16 (a) Informant Mrs. Bernice A. Cook
(b) Address 911 N. Arlington Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1 28 46
(month) (day) (year)

(c) Cemetery or crematory Balto. Natl.
Location Balto. Co.

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date rec'd (month) (day) (year) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1946, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-23-46 at P. 17/1 M.
(b) Where did injury occur? 911 Argyle ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Gas escaped from oven.

23. Signature Wm. S. Hayford Jr. in Kitchen
Chief Medical Examiner. M.D.
Date signed 1-24-46 , M. D.

VS 151

636770 ✓ 636770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

472 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25 S. Culver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Culver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Charles L. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jeanie Curnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1889

8. AGE: Years 56 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Henry Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Brik
15. Birthplace Balto Md.

16 (a) Informant Mrs. Jeanie C. Schmidt
(b) Address 25 S. Culver St.

17 (a) Cremation (b) Date thereof Jan 24 46
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery, or~~ crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Lichte
(b) Address 4101 Edmondson Ave

19 (a) JAN 25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23/46, 19..., at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19..., and that I last saw h... alive on ... 19... Not seen alive.

Immediate cause of death Edema of Lungs, due to anemia & general debility — Duration 2 hrs.

Due to Carcinoma of Trachea — 2 yrs.

Due to primary in epiglottis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ~~None~~

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo. E. Wells M. D.
Address 4100 Edmondson Ave Date signed 1/23/46

VS 150 The above cause I took from hospital records. H. J. Madeira, M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Holder for S.A. Friday 2/1/46

G36771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36771 Registered No. 1864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 E. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Penn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 39 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Penn
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Slaine
15. Birthplace Md.

16 (a) Informant ROBERT L PENN
(b) Address 335 E. HAMBURG ST

17 (a) Burial (b) Date thereof 1/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director William Cook Sons
(b) Address 1217 St. Paul St.

19 (a) JAN 25 1946 (b) Huntington for Williams
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1946, at 3:38 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from; natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull.

Due to

Other Conditions Cirrhosis of liver, Arteriosclerosis & Splenomegaly.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-23-46 3 P. 23/2 M.
(b) Where did injury occur? Cross Street market in front of store
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? NO
(d) Means of injury Fell striking iron pillar

23. Signature Howard J. Tilden M.D.
Medical Examiner.
Date signed 1-25-46

G36772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. G36772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOA
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4h
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Simms

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 25 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1946 at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinske M.D.
Medical Examiner.
Date signed 1/13/46

VS 151

3258 X

636773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

Registered No. 636773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 E. Lexington
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Roy F. Heasley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	9		....hr. ....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School JAN 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address.....

JAN 25 1946 Hunter for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1946, at 11:55 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to.....

Other Conditions Enlargement of Thymus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Faston M.D.
Medical Examiner.
Date signed Jan 14 1946

VS 151

G36774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G36774
Registered No.

Type or print the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Baltimore st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Haskins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 25 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 25 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1946, at 3:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy/Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stavaridis M.D.
Medical Examiner.
Date signed 1-18-46

VS 151

5256 X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36775 46a

Registered No. G36775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 E. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Bartoschiewicz

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ANNA BARTOSKEWICZ

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1841

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace: LITHUNIA
(Town, county, and state)

10. Usual Occupation: TAYLOR

11. Industry or business: FOR SELF

FATHER
12. Name: KAZMIER BARTOSKEWICZ
13. Birthplace: LITH.

MOTHER
14. Maiden Name: MARIOAN ?
15. Birthplace: LITH.

16 (a) Informant: NANA BARTOSKEWICZ(WIFE)
(b) Address: 1625 SHAKESPEARE ST.

17 (a) BURIAL (b) Date thereof JAN. 26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn md.

18 (a) Funeral director Libby & Zeile inc.
(b) Address 403 S. WOLFE ST.

19 (a) JAN 25 1946 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1946, at 3 10 P.M.

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Esophagus

Due to

Other Conditions Emaciation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 23 1946

G36776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G36776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Binau, Joseph

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1888

8. AGE: Years 57 | Months 10 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Conrad Binau
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hamilton
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Metals
Location Frederick Road

18 (a) Funeral director Odell Funeral Home Inc.
(b) Address 4644 York Rd.

19 (a) (Signature for city registrar) (b) for Williams, M.D. Registrar

JAN 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1946, at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1946, to Jan. 24 1946, and that I last saw him alive on Jan. 24 1946

	Duration
Immediate cause of death: #1- Lobar pneumonia, right upper lobe	2 wks
Due to #2- Nephrosclerosis severe with cardiac hypertrophy	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 1/25/46

US Marine Hospital, Balto, Md.

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G36777 51C Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR WRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 254 S. 45th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Nisbet, Douglas Steffian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1916

8. AGE: Years 30 | Months 0 | Days 1 | If less than one day: hr. min.

9. Birthplace Harrisburg, Pa.
(Town, county, and state)

10. Usual Occupation PA Surgeon

11. Industry or business US PHS

FATHER
12. Name Verner S. Nisbet
13. Birthplace S.C.

MOTHER
14. Maiden Name Emma Steffian
15. Birthplace Texas

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan 25/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Oxley Funeral Homes Inc.
(b) Address 4644 York Rd

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 25 1946

Hunting for Nisbet

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1946, at 8:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1945, to Jan. 25 1946, and that I last saw him alive on Jan. 25 1946.

Immediate cause of death Carcinoma of testicle, postoperative with pulmonary and renal — Duration 1 yr

Due to metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W B Hoover M.D.
William B. Hoover, Surgeon
Address US PHS Date signed 1/25/46
US Marine Hospital, Balto, Md.

36778

BALTIMORE CITY HEALTH DEPARTMENT X V G36778

CERTIFICATE OF DEATH 198 Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Typewriters should be used if currently supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 10
(e) Length of stay in Baltimore (yrs., mos., or days) ~~2 mos. 10 days~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Tasker

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1923

8. AGE: Years	Months	Days	If less than one day
22	10	8	hr. min.

9. Birthplace Anne Arundel Co., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Arthur Tasker
13. Birthplace Anne Arundel Co. Md

MOTHER
14. Maiden Name Louise Dowell
15. Birthplace Owensville, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address
JAN 25 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1946 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1945, to Jan. 18 1946 and that I last saw him alive on Jan. 18 1946

Immediate cause of death	Duration
Dislocation of 5th cervical vertebra	
Due to: Execution by hanging	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Embry M.D.
Address Temple Court Apts. Date signed 1-18-46

VS 180

3259

G36779

BALTIMORE CITY HEALTH DEPARTMENT ✓ G36779

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH: 315 - Wesley ct.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 - Wesley ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Sleppfeld

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: col | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Bolling Green, Va.
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant John Jackson
(b) Address 308 - Wesley ct.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 25 1946 (Signature) Justin A. Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1946, to Jan 17 1946, and that I last saw him alive on Jan 17 1946

Immediate cause of death Coronary Thrombosis | Duration

Due to

Due to

Other Conditions Duodenal Ulcer
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John O. Johnson M.D.
Address 2329 Guilford Ave. Date signed Jan 25 1946

V8 150

3260

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

536780 Le Birth 39327 ✓ BALTIMORE CITY HEALTH DEPARTMENT ✓ 119a

CERTIFICATE OF DEATH

Registered No. 536780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 33
(e) Length of stay in Baltimore (yrs., mos., or days) 33

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Whitelock St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Hurley ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Infant

6 (b) Name of husband or wife Alice Hurley
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-20-45

8. AGE: Years	Months	Days	If less than one day
	1	23	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 25 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-46 at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1945 to 1-22 1946, and that I last saw h— alive on 1-22 1946.

Immediate cause of death Premature

	Duration
Due to Epidemic Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mathews Drake M. D.
Address Univ Hosp Date signed 1-24-46

correct age is especially important. Physicians: please write the

VS 150

3261 X

G36781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G36781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1546 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ferrel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Child.

6 (b) Name of husband or wife Esther Ferrel
6 (c) If alive, give age 17 years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1946

8. AGE: Years — | Months — | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Robert Ferrel
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) City Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 25 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1946, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1946 to 1-23 1946, and that I last saw him alive on 1-23 1946.

	Duration
Immediate cause of death Pneumonia	
Due to Epidemic Diarrhea	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter L. Drake M. D.
Address Univ. Hospital Date signed 1-24-46

correct age is especially important. Physicians: please write the

VS 150

F 3262

G36782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a G36782 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 264 S East Ave
(c) Hospital or institution:

26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 264 S. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander S. DeFabio

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Florence R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1886

8. AGE: Years 59 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Alexander DeFabio
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Marie Hiss
(b) Address 225 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4200 Belair Road

18 (a) Funeral director Martin H. C. Dippelsman
(b) Address Loreland & Ann Sts.

19 (a) 1-25-1946 (Date received by registrar) (b) Huntingtown Prince Georges Co. Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1946, at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Jan 23 1946, and that I last saw him alive on Jan 21 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 1 month & 23 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Davidson M. D.
Address 3218 Eastern Ave Date signed

G36783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G36783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Germany

3 (a) FULL NAME Clara Schwartz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife Frank Schwartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1863

8. AGE: Years 82 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name John Brown
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) Filed Jan 25 1946 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946, at 2-20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2- 1946, to Jan 24 1946, and that I last saw h- alive on Jan 24 1946.

Immediate cause of death	Duration
Edema Lungs	1 day.
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions Cerebral Arteno - Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E Northern Date signed 1/25/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

VS 150

2 Ja Pm X

G36784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 55 B

Registered No. G36784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Finksburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Near Westminster (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. James Elseroade

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26 1894

8. AGE: Years	Months	Days	If less than one day
53	11	-	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Pleasant Memorial
Location Finksburg, Carroll Co. Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

JAN 26 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/1946, at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/1946 to 1/26/1946 and that I last saw him alive on 1/25/1946.

	Duration
Immediate cause of death: Congestive Heart Failure	18 hrs.
Due to: Metastatic Carcinoma	1 Mo.
Due to: Operation 1/23/46 C.A. Vertebrae	3 Days
Other Conditions: Nephritis	

(Include pregnancy within 3 months of death)

Date of operation 1/23/46

Major findings of operation: C.A. Vertebrae

Site of autopsy: None Spinal Canal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Porter Jr. M.D.
Address Westminster Md. Date signed 1/26/46

correct age is especially important. Physicians: please write the

VS 150

G36785 CARNELL G36785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Elm ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Richard Allen Carnell

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11- 1945

8. AGE: Years	Months	Days	If less than one day
—	4	13	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Ivan E. Carnell
13. Birthplace Columbia S.C.

MOTHER
14. Maiden Name Lucille Williams
15. Birthplace Virginia

16 (a) Informant Ivan E. Carnell
(b) Address 3003 Elm Avenue

17 (a) Burial (b) Date thereof Jan 26 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Marys Hamsden
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 2631 Falls Road

19 (a) JA 26 1946 (b) Interring for Williams M.T.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 24 - 1946, at 5 40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation

Due to Overlying of mother

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24- at 1215 A.M.
(b) Where did injury occur? 3003 Elm ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Overlaying of mother in bed.
23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 1-24-46

VS 151

FL - 636786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. 636786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 10 - 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Amity St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1861

8. AGE: Years 84 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emily ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germantown Pike Md

18 (a) Funeral director Fahey & Sons
(b) Address 3418 Liberty Hts Ave

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1946 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1930 to Jan. 18 1946, and that I last saw h im alive on Jan. 18 1946

Immediate cause of death	Duration
Caressing of the Stomach	
Due to	
Due to	
Other Conditions Metastasis to Liver (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address 2-C-H. Date signed 1/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

VS 150

G36787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36787

G36787 /61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3028 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3028 E Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise N. Krajna

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Krajna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24 1875

8. AGE: Years 70 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Casimir Drozd
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Frank Krajna
(b) Address 3028 E Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28 /46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Thos. Williams, Registrar

JAN 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1946 to Jan 1946 and that I last saw h[illegible] alive on Jan 24 1946.

Immediate cause of death: Diabetes Mellitus — Duration 15 yrs
Hypothyroxemia C.V.R Decrease
Due to Chr. Myocarditis — 1-21-46
Senile Coronary Thrombosis
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E Abkemeneck M. D.
Address 842 S Ex Ave Date signed 1-25-46

X

G36788

BL - 9515S

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G36788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 16
9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 993 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Nan (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? 1885

8. AGE: Years 60 61 Months ? 7 Days ? If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Va.

MOTHER
14. Maiden Name Martha
15. Birthplace Va

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto Co - Md

18 (a) Funeral director Chas Alexander
(b) Address 927. N. Mechanic St.

19 (a) JAN 26 1946 (Date rec'd by registrar) Printing for Williams M.F. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 1945 to Jan. 20 1946 and that I last saw h 1m alive on Jan. 20 1946

Immediate cause of death Syphilitic heart. Disease and
Due to Aneurism the aorta
Due to and cardiac failure
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Probable

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B C H Date signed 1/25/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

AB-08538 636789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

636789

Registered No. 13 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-15-1915

8. AGE: Years 30 | Months 3 4 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oliver Cole
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Mason
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 29 46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l Pk
Location Baltimore Md

18 (a) Funeral director William A Parkson
(b) Address 916 Pendra ave

19 (a) (Delivered to registrar) (b) Registrar

JAN 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1946 at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1945 to 1-25 1946, and that I last saw h ER alive on 1-25- 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to: Pulmonary Tuberculosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 1-25-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G36790 BALTIMORE CITY HEALTH DEPARTMENT G36790

CERTIFICATE OF DEATH 336

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1145 Shields Pla
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 Shields Pla (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-20-1867

8. AGE: Years	Months	Days	If less than one day
78	3	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lillian Rogers
(b) Address 1145 Shields Pla

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 28 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore County Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

JAN 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to 1-24 19 46
and that I last saw h[illegible] alive on 1-23-46

Immediate cause of death: Gangrene Arteriosc. — Duration 10 Days
Due to: Infirmities of Age
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alice Allen
Address 914 McCulloh Date Jan 29 46 M. D.

Hunter for Pittman

X

G36791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

Registered No. G36791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Month

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 E 33rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary M Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ George T Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Mass
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Strimatitis
13. Birthplace Poland

MOTHER
14. Maiden Name Alice Bankhouse
15. Birthplace Poland

16 (a) Informant George T Cooper
(b) Address 828 E 33rd St

17 (a) Burial (b) Date thereof Jan 28-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Parkville, Md.

18 (a) Funeral director W W Chamberlin Co
(b) Address Rimdale, Md.

19 (a) JAN 26 1946 Huntington Williams, M.D.
(Date received) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1946, at 3:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1945 to 1/26 1946 and that I last saw her alive on 1/26 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to CA of Breast c Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Baggett M.D.
Address 1 Parkview Ter Hosp Date signed 1/26/1946

correct age is especially important. Physicians: please write the

VS 150

Please write the causes of death clearly and legibly.

636792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 636792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 N. Glover Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Glover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John M. Hudson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 25 1874

8. AGE: Years 71 | Months 1 | Days - | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dont Know
15. Birthplace Baltimore

16 (a) Informant Mrs. Helen Hudson
(b) Address 248 N. Marlyn Ave. Essex

17 (a) Burial (b) Date thereof Jan 28-
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem
Location Catonsville

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) JAN 26 1946 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1946, at 8 A M

21. I certify that I took charge of the remains described above, held an ... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellen M.D.
Medical Examiner.
Date signed 1-25-46

536793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46 B

Registered No. G36793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution:
UNION MEMORIAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Anne Arundel
(c) City or town RURAL SUNSET KNOLL. PASADENA MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. LIST AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** MR. ROBERT KARL

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MRS ROBT KARL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 20 1891

8. AGE: Years 54 | Months 54 | Days 5 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation RESTAURANT, BLDG ASSN

11. Industry or business

FATHER
12. Name JOHN KARL
13. Birthplace GERMANY

MOTHER
14. Maiden Name BARBARA SWARTZMAN
15. Birthplace GERMANY

16 (a) Informant Mrs. Elizabeth Karl
(b) Address List Ave. Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1:29:46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 JAN 26 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 25 1946, at 12 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 21 1946 to JAN 25 1946, and that I last saw him alive on JAN 25 1946.

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to URAEMIA DUE TO POST. OP. ANURIA

Due to PARTIAL GASTRECTOMY 3 DAYS AGO FOR CARCINOMATOUS ULCER

Other Conditions HYPERTENSIVE CARDIOVASCULAR DISEASE BLEEDING FROM LOWER BOWEL

(Include pregnancy within 3 months of death)

Date of operation JAN. 23 1946

Major findings of operation: CHRONIC ULCER & GASTRITIS & CARCINOMATOUS(?) CHANGES

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul S. Casale M. D.
Address U. M. Hospital Date signed 1-25-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G36794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36794 Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 E. Lanvale Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 E. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DAISY BELL MERRICK

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Herman Merrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1878

8. AGE: Years 67 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Dorchester Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas W. Corkran
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Mary Elizabeth ?
15. Birthplace Dorchester Co., Md.

16 (a) Informant Mr. Henry Pragel
(b) Address 4009 Eierman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28, 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

JAN 26 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1946, at 11.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1945, to Jan. 24 1946 and that I last saw h. alive on Jan 24 1946

Immediate cause of death: congenital insufficiency Duration: 3 day
Due to: cirrhosis of the liver. 4 yrs.?
Due to: ?
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature L. C. Sobieski
Address 4474 N. Kenwood Ave Date signed 1/28/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G36795 BALTIMORE CITY HEALTH DEPARTMENT X G36795

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street.
(c) Hospital or institution:
South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 6th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Minnetta Stroup

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife John Stroup
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1867

8. AGE: Years	Months	Days	If less than one day
78	10	22	hr. min.

9. Birthplace Maryland
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Allison
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachael Freeman
15. Birthplace Maryland.

16 (a) Informant Alethia Forsacke
(b) Address Jessup Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Lorraine
Location Frankelintown rd.

18 (a) Funeral director Ambrose Inc.
(b) Address 414 N. Frankelintown rd.

19 (a) JAN 26 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1946 at 4 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1945 to 1/24 1946 and that I last saw her alive on 1/24 1946

Immediate cause of death Cerebral Thrombosis — Duration

Due to Arterio Sclerotic heart disease

Due to

Other Conditions Subtrochanteric fracture left femur

(Include pregnancy within 3 months of death)
Date of operation 12/13/45
Major findings of operation: Kirschner wire placed
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 10 1946 M
(c) Where did injury occur? Brooklyn Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell on floor at home
23. Signature Dr. Newton Wms
Address 5 Balls Lane Date signed 1/25/46 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150 For Dr. Wm. G. Hefelbt, by Howard J. Unverzagt, M.D.

G36796 G36796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No.

Every item of information should be carefully handled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 E. Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1906

8. AGE: Years	Months	Days	If less than one day
39	11	10	hr. min.

9. Birthplace N. Carolina
(Town, county, and state)

10. Usual Occupation Hucklster

11. Industry or business

FATHER
12. Name Noah Ford
13. Birthplace N. C

MOTHER
14. Maiden Name Ida Thurgood
15. Birthplace N. C.

16 (a) Informant Ida Ford
(b) Address 1836 E Chase St

17 (a) Burial (b) Date thereof Jan 26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1329 N. Carolina St.

19 (a) (b)
(Signature of local registrar) Registrar

JAN 26 1946
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945, to Jan 1946, and that I last saw h[illegible] alive on Jan 22, 1946.

Immediate cause of death

Tuberculosis Pul — Duration

Due to Pneumonic tuberculosis 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Luke M. D.
Address 1201 E. Eager St. Date signed 1-26-46

G36797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 10

G36797 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 West Lombard ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Riddell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 23 1942

8. AGE: Years	Months	Days	If less than one day
3	8	1	hr. min.

9. Birthplace BALTIMORE, MARYLAND.
(Town, county, and state)

10. Usual Occupation CHILD.

11. Industry or business

FATHER
12. Name GUSTAV FRANCIS Riddell
13. Birthplace BALTIMORE, MARYLAND

MOTHER
14. Maiden Name VIOLA MAY Smith
15. Birthplace BALTIMORE MARYLAND

16 (a) Informant VIOLA MAY Riddell
(b) Address 706 West Lombard ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 3900 Frederick Road

18 (a) Funeral director John J. Conroy Son
(b) Address 901 Hollins St

19 (a) 1/26 1946 (Date received) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-46 1946, at 7:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1946, to 1-24 1946 and that I last saw her alive on 1-24 1946.

Immediate cause of death	Duration
HEART Failure	
Due to MYOCARDITIS.	
Due to DIPHTHERIA.	
Other Conditions TRACHEOTOMY.	

(Include pregnancy within 3 months of death)

Date of operation 1-24-46

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Sydenham Hosp Date signed 1/24/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly, with UNFADING INK.

G36798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1634 Registered No. G36798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caton Aves
(c) Hospital or institution
Franklin Square Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E Coleman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife John J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1883

8. AGE: Years	Months	Days	If less than one day
62	6	20	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name Terence Flanagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Morris
15. Birthplace Ireland.

16 (a) Informant Mr John J. Coleman
(b) Address 1009 N. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director John F. Conway & Son
(b) Address 900 E. Fayette St.

19 (a) [illegible] (Date rec'd by Registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1- 24- 1946, at 2.20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to illuminating Gas
Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1- 24- at 0 M.
(b) Where did injury occur? 1009 N. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Open burner gas gets on kitchen range

23. Signature Howard J. Hemeleis M.D.
Medical Examiner.
Date signed 1-25-46

G36799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 868 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 868 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERNESTINE CLARA JORDAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James Henry Jordan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1880

8. AGE: Years	Months	Days	If less than one day
65	6	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George B. Kaufman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Anne Miller
15. Birthplace Balto., Md.

16 (a) Informant Mr. James H. Jordan
(b) Address 868 W. Lombard St.

17 (a) Burial (b) Date thereof 1/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 26 1946 (b) Huntington Williams M.D.
(Date rec'd by Reg.) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1946, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Jan 24 1946 and that I last saw her alive on Jan 22 19 46

Immediate cause of death	Duration
Myocardial Failure	several days
Due to Arteriosclerotic C. V.D.	several years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Senator Hechtman M. D.
Address 888 W. Lombard St Date signed 1-25-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G36800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G36800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 Herbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES C. WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mattie Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1869

8. AGE: Years	Months	Days	If less than one day
76	4	24	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Miss Madeline Logue, Granddaughter
(b) Address 2131 Herbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 26 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1946, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17-1946 to 1-24-1946 and that I last saw h. l. alive on 1-24-1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to adv. Atherosclerosis	
Due to	
Other Conditions Chr Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Jacobs M. D.
Address 1700 Eutaw Pl. Date signed 1-25-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 150

94a

G36801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G36801

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 347 S. Furrow St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 347 S. Furrow St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Schuhmacher.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife John F. Schuhmacher
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 27-1862

8. AGE: Years	Months	Days	If less than one day
83	11	28	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation House Wak - Retired.
11. Industry or business

FATHER
12. Name George Hemming.
13. Birthplace Germany.

MOTHER
14. Maiden Name Elizabeth Miem.
15. Birthplace Germany.

16 (a) Informant Philip G. Schuhmacher.
(b) Address 347 S. Furrow St.

17 (a) Buried. (b) Date thereof Jan. 28. 1946.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore - Md.

18 (a) Funeral director Charles P. Schwab
(b) Address 505 N. Monroe St. Baltimore, Md.

JAN 26 1946 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24th. 1946. at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945. to Jan 24 1946. and that I last saw h alive on Jan 24 1946.

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Terminal	
Due to General and Cerebral Arterio Sclerosis	9 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 843 Druid Park Ave. Date signed

G36802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

G36802

Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important. PRINTING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 144 No Pine St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 144 No Pine St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert H. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-3397

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 16 1914

8. AGE: Years 32 | Months — | Days 2 | If less than one day ... hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Printing Engraving Paper

FATHER 12. Name Henry G. Wagner

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Matilda Mannenbaum

15. Birthplace Balto Md.

16 (a) Informant Henry G. Wagner

(b) Address 144 No Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 (month) (day) 1946

(c) Cemetery or crematory Westview

Location Baltimore, Md

18 (a) Funeral director F. B. Shipley & Son

(b) Address 650 W. Baltimore St

19 (a) JAN 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1944 to Jan 25 1946, and that I last saw him alive on Jan 24 1946.

Immediate cause of death: Pulmonary Oedema

Due to Myocarditis

Due to Pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Nathan C. Hitch M.D.

Address 2157 Wilkens Ave Date signed 1/27/46

636803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 636803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Linden Ave (If rural give location)
(e) Citizen of foreign country? W. (Yes or No)
If yes, name country

3 (a) FULL NAME Murray Willis

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-4908

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nannie G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1[illegible]

8. AGE: Years 62 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John F. Willis
13. Birthplace Fredericksburg, Va.

MOTHER
14. Maiden Name Lucy Murray
15. Birthplace Charlestown, Md.

16 (a) Informant Mrs. Nannie G. Willis
(b) Address 714 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memy. Pk. Baltimore Co. Md.
location

18 (a) Funeral director Mrs. Lee A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 27 1946 (Date rec'd by registrar) (b) Burlington Williams Md. (Signature)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1946 to 1/23 1946 and that I last saw h[illegible] alive on 1/23 1946

Immediate cause of death: Lobar Pneumonia — Duration 3 wks.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 4[illegible] W. Biddle St. Date signed 1/25/46

correct also especially important. Physicians: please write the causes of death clearly and legibly.

G36804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G36804

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Chapel Gate Lane

(b) Street address ~~Ventnor Lodge~~

(c) Hospital or institution: Ventnor Lodge 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

526 1

(d) Street No. Chapel Gate Lane (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs Carrie L Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21 - 1870

8. AGE: Years	Months	Days	If less than one day
75	1	21 4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation clerical work

11. Industry or business

12. Name William Taylor

13. Birthplace Baltimore md

14. Maiden Name Mary S McHett

15. Birthplace Baltimore

16 (a) Informant Mrs. Fran Prof

(b) Address 2537 W Lanvale St

17 (a) Burial (b) Date thereof Jan 28-46 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location

18 (a) Funeral director Charles P Powell

(b) Address 2427 Edmondson Ave

19 (a) Date rec'd by Registrar JAN 26 1946 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 25 1945 to Jan. 25 1946, and that I last saw h[illegible] alive on Jan. 22 1946.

Immediate cause of death	Duration
Acute cardiac failure	1 hr
Due to arteriosclerotic deterioration	years
Due to senile atrophy	
Other Conditions Intermittent	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Rachel K Gundry M. D.

Address 5002 Frederick Rd, Balto 29 Date signed 1-25-46

VS 2

RACHAEL K. GUNDRY - M.D.X

636805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

✓ 636805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2607 Springhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 Springhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Scherr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 68 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Rigar
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Michael ?
13. Birthplace Riga

MOTHER
14. Maiden Name Bessie Lebauer
15. Birthplace Riga

16 (a) Informant Mrs Bessie Wolfson
(b) Address 2607 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cemetery
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 27 1946

VS 150

MEDICAL CERTIFICATION 11.08

20. DATE OF DEATH January 25 1946 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1940 to 1/25 1946 and that I last saw h[illegible] alive on 1/25 1946.

Immediate cause of death Edema
Myocarditis
+ Arteriosclerosis

	Duration
Due to	
Due to	
Other Condition Chronic Gall Bladder	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1111 Lee St Date signed 1/26 M. D.

X 1/26

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36806 ✓ G36806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale Home
(c) Hospital or institution: Belvedere & Greenspring Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Chait

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Yetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years	Months	Days	If less than one day
90 89			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry Hyatt
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Ruusia

16 (a) Informant Jacob Hyatt
(b) Address 18 N. Collington Ave

17 (a) Burial (b) Date thereof Jan. 27. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W. North Ave

19 (a) (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1946 at 4.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1945 to 1-24 1946, and that I last saw h[illegible] alive on 1-24 1946.

Immediate cause of death	Duration
Carcinoma of oesophagus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-19-45

Major findings of operation: Ca of oesophagus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin M. D.
Address Levindale Date signed 1/24/46

VS 100

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36807 ✓ G36807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

Every item of information should be carefully supplied. They correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1800 McCulloh
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conway Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ollie Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Robinson Co, N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Andrew Brown
13. Birthplace N.C.

MOTHER
14. Maiden Name —
15. Birthplace N.C.

16 (a) Informant Nolan Elliott
(b) Address 2407 Round Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-46 (month) (day) (year)
(c) Cemetery or crematory Fayetteville N.C.
Location N.C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Round Hill Ave.

19 (a) 1/27/46 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 4:45 P

20. DATE OF DEATH Jan 24 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1946 to Jan 24 1946. and that I last saw h. alive on Jan 24 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Tiskin M. D.
Address 1642 E Monument St Date signed 1-24-46

VS 150

G36808 BALTIMORE CITY HEALTH DEPARTMENT G36808

CERTIFICATE OF DEATH 1578 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4511 Pimlico Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rona Cohen

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-46

8. AGE: Years | Months | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Mr. Jerome Cohen
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mrs. Jerome Cohen
15. Birthplace Balto. Md.

16 (a) Informant Mr. Jerome Cohen
(b) Address 4511 Pimlico Rd.

17 (a) Burial (b) Date thereof 1-27-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Levinson Circle
Location Mt. Carmel

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto. St

19 (a) 1-27 1946 Harrington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1946, at 5:13 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1946 to 1-26 1946, and that I last saw him alive on 1-26 1946.

Immediate cause of death: Respiratory Failure — Duration: 2 weeks

Due to

Due to

Other Conditions: Spina Bifida

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N Kazerman M. D.
Address Franklin Square Hosp. Date signed 1-26-46

VS 150

Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36809 X ✓ G36809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

Every item of information should be carefully supplied. (Type) Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Jefferson Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emily Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife John W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-80

8. AGE: Years	Months	Days	If less than one day
65	10	25	hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Isaac Killett

13. Birthplace Eng.

MOTHER 14. Maiden Name Annie Salisbury

15. Birthplace ?

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVENUE

18 (a) Funeral director M. F. Sadowski & Son

(b) Address 1818 Eastern Ave

19 (a) (b) Date received by registrar Registrar

N 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946 to Jan 26 1946 and that I last saw h alive on Jan 4 1946.

Immediate cause of death Coronary occlusion

Due to Hypertension & Cardio-vascular disease

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Hendrix M. D.

Address Johns Hopkins Hosp. Date signed 1/26/46

925

G36810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G36810

51c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town ROGERS FORGE (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 MURDOCK ROAD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John David Finn JOHN DAVID FINN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife HEDWIG

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 3/4/05

8. AGE: Years 40 - | Months 10 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation MAIL CARRIER

11. Industry or business

FATHER
12. Name JOHN J. FINN
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name EMMA SYKES
15. Birthplace GERMANY.

16 (a) Informant MRS. HEDWIG FINN
(b) Address 231 MURDOCK ROAD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS.
Location MT. CARMEL ROAD.

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 EASTERN AVE.

19 (a) JAN 27 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1946, at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26/1946, to 1/24/1946, and that I last saw him alive on 1/24/1946

Immediate cause of death: Pulmonary Edema — Duration: 10 days

Due to Metastatic C.A. Lungs — 1 mo.

Due to Spinal Cord Lesion — 1 mo.

Other Conditions C.A. Testicle Treated (Removed)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Teratoma - Testicle

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Thos. Anton Jr.

Address Bon Secours Hosp Date signed 1/24/46 M.D.

correct age is especially important. Physicians: please write the

VS 150

G36811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36811 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland St. Joseph Hosp.
(b) Street address ~~3132 Cliftmont Ave.~~
(c) Hospital or institution Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 Cliftmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Bailey
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Richard J. Bailey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 31 1883
8. AGE Years 62 Months 5 Days 24 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name John J. Calder
13. Birthplace Baltimore Md.
MOTHER 14. Maiden Name Larkins
15. Birthplace Ireland
16. (a) Informant Richard J. Bailey
(b) Address 3137 Cliftmont Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.
18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St. Baltimore, Md.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1946 at 7:40 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946 to 1/24 1946 and that I last saw her alive on 1/24 1946
Immediate cause of death Cardiac Failure
Due to Chronic Hypertension
Cardio Vascular Disease
Due to
Other Conditions Vaginal Bleeding
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Peter Tsouklis M. D.
Address Date signed 1/24/46

Incorrect age is especially important. Physicians: please write the correct the causes of death clearly and legibly. Every item of information should be carefully supplied. The

27 1946
VS 150

3724 G36812 BALTIMORE CITY HEALTH DEPARTMENT X G36812
CERTIFICATE OF DEATH 46B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 FRANOI St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert E. McNasby
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Cecelia McNasby
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) 8-12-84
8. AGE: Years 61 | Months 5 | Days 17 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Oyster Packer
FATHER 12. Name William McNasby
13. Birthplace Md.
MOTHER 14. Maiden Name Mary Brittner
15. Birthplace Md.
16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cem
Location Annapolis Md
18 (a) Funeral director E. W. Longrear
(b) Address 1003 W. Baltimore St
19 (a) Filed JAN 27 1946 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 - 1946 at 9 10 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-6- 1946 to 1-26- 1946 and that I last saw h alive on 1-26- 1946.
Immediate cause of death Postoperative peritonitis. Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1-8-46
Major findings of operation: Carcinoma of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John A. Elder Jr M. D.
Address Johns Hopkins Date signed 1-27-46

VS 150

correct age is especially important. Physicians: please write the

G36813 BALTIMORE CITY HEALTH DEPARTMENT G36813
Registered No.

CERTIFICATE OF DEATH 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Oella Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cross

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-12-2203

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1868

8. AGE: Years	Months	Days	If less than one day
77	1	2	hr. min.

9. Birthplace France
(Town, county, and state)

10. Usual Occupation Weaver

11. Industry or business Woolen Mill

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Friend
(b) Address

17 (a) Burial (b) Date thereof Jan 30, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City, Md.

18 (a) Funeral director Easton & Sons
(b) Address Ellicott City, Md.

19 (a) (b) Huntington Williams Registrar
(Filled in by registrar)
JAN 27 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1946 at 8 30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra Cranial Hemorrhage, traumatic

Due to Fractures of Skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-26-46 at Balto. Co. 8 P. M.
(b) Where did injury occur? 101 Oella Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down stairs

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Jan 27 1946

G36814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G36814
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 Hunter Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Hunter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elnora Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/1894

8. AGE: Years 51 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Crewe, Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Jennings
13. Birthplace Crewe, Va

MOTHER
14. Maiden Name Ella Thomas
15. Birthplace Crewe, Va

16 (a) Informant Marria Campbell
(b) Address 2307 Hunter Street

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 1/27/1946 (month) (day) (year)

(c) Cemetery or crematory
Location Crewe, Va

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston Street

19 (a) 1946 (Date rec'd by registrar) for Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1946, at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 1944, to 1 1946, and that I last saw h. alive on Jan 26 1946

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Essential Hypertension	5 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emerson R. Julian M. D.
Address 434 E 23rd St Date signed 1/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G36815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G36815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 Mosaic Court
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Walker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18, 1880

8. AGE: Years	Months	Days	If less than one day
65 66	10	4	.....hr. .....min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Walker
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Cora Walker
(b) Address 1041 Eutaw St.

17 (a) Burial (b) Date thereof 1/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Raynor Sanders
(b) Address 1412 E. Preston Street

19 (a) JAN 27 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22/46 19..... at 11:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular

Due to Disease

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 1/23/46

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X

G36816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581B Registered No. G36816

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sanai Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N Kenwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Przybyl (Sr.601)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-995

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Martha Przybyl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1904

8. AGE: Years 41 | Months 7 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name John Przybyl
13. Birthplace Poland

MOTHER
14. Maiden Name Magdalena Kaiser
15. Birthplace Poland

16 (a) Informant Mrs Martha Przybyl

(b) Address 228 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester Street

19 (a) 27 1946 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 6

20. DATE OF DEATH Jan 25 1946, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1945 to Jan 24 1946, and that I last saw him alive on Jan 24 1946.

Immediate cause of death Pneumonia - interstitial hemorrhage, inflated perforation & peritonitis — Duration

Due to Lobar pneumonia, bacterial Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Hirschman M. D.

Address Sinai Hospital Date signed 1/25/46

J.H. HIRSCHMAN, M.D. X

G36817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G36817

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5202 Belair Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give location)
(d) Street No. 5202 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret V. Noblette

3 (b) If veteran, name war: No
(c) Social Security Account No.: None

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel F.
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) Dec 17 1884
8. AGE: Years 61 | Months 1 | Days 7 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joseph Gilk
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Müller
15. Birthplace Germany

16 (a) Informant Samuel F. Noblette
(b) Address 5202 Belair Rd

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 28 1946 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE

18 (a) Funeral director MARTIN W.E. DIPPEL'S SONS
(b) Address 7110 BELAIR ROAD

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 27 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Jan 24 1946 and that I last saw h[illegible] alive on Jan 24 1946.

Immediate cause of death: Luetic Aortic insufficiency — Duration: 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 6217 Harford Rd Date signed 1/28/46

G36818 G36818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193E

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth F. McCabe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6th 1866.

8. AGE: Years	Months	Days	If less than one day
79	1	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business

FATHER 12. Name John McC. Cabe
13. Birthplace Ireland
MOTHER 14. Maiden Name Bridget Doyle
15. Birthplace Ireland

16 (a) Informant Mrs. John F. McC. Cabe
(b) Address 1614 Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Bowen & Son
(b) Address 901-03 Baltimore St

19 (a) 1 7 1946 (Date rec'd by registrar) (b) Keating for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1946, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 | 24 | 1946 to 1 | 25 | 1946, and that I last saw h[illegible] alive on 1 | 25 | 1946

Immediate cause of death: Acute Cardiac Dilatation — Duration

Due to: Chronic Myocarditis — Duration

Due to: Chronic Nephritis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. C. Fleteman, M.D.
Address 1441 E Balto St Date signed 1/27/46

VS 150

G36819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 78B

G36819 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Loarey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Rohl

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-2-44

8. AGE: Years	Months	Days	If less than one day
1	22 10	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Ravern Rohl
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary Treege
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2900 Frederick Road
18 (a) Funeral director Jolue & Conway Son
(b) Address 90-03 Baltimore St.
19 (a) (Date rec'd by registrar) (b) Registrar

JAN 27 1946

VS-350 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1946 at 10. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1946 to Jan. 25 1946, and that I last saw him alive on Jan. 25 1946.

Immediate cause of death Lead encephalopathy — Duration
Due to Lead poisoning — 1 month
Due to
Other Conditions Anemia — over
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter M. Tavern M. D.
Address J. H. H. Date signed 1-26-46

G36820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Columbia N.C.
(c) Hospital or institution:
Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Columbia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Samuel S. Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife May C. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28-1880

8. AGE: Years	Months	Days	If less than one day
65	3	28	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Edward Clark
13. Birthplace N.C.

MOTHER
14. Maiden Name Martha Spencer
15. Birthplace N.C.

16 (a) Informant May C. Clark
(b) Address Columbia. N.C.

17 (a) Burial-Transit (b) Date thereof 1/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hyde Co.
Location N.C.

18 (a) Funeral director William Cook Inc.
(b) Address 1424 St. Paul St.

19 (a) 1-29-1946 (b) at 1 P.M.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1946, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1946, to 1-26 1946, and that I last saw h alive on 1-26 1946

Immediate cause of death	Duration
Uremia	4 days
Due to	
Renal Insufficiency	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-16-46
Major findings of operation: Ureteral Calculus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 1-26-46

correct age is especially important. Physicians: please write the

X

G36821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G36821 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 21

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 W. Rogers St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas B. Sanger

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or wife~~: Bernadine F. Sanger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2nd 1878

8. AGE: Years	Months	Days	If less than one day
67	10	23	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Entertainer
11. Industry or business Self

FATHER
12. Name Unknown Sanger
13. Birthplace U

MOTHER
14. Maiden Name U
15. Birthplace U

16 (a) Informant Bernadine F. Sanger
(b) Address 3706 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul, St.

JAN 28 1946 (Date rec'd by Registrar) (b) Evington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 19 46 at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 19 46 to Jan 25 19 46 and that I last saw ~~him~~ alive on Jan 25 19 46

Immediate cause of death: Toxemia from diffuse late peritonitis — Duration

Due to perforated appendix

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1-23-46
Major findings of operation: abscess, in R.L.Q.
of autopsy: 1-26-46 (peritonitis)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm A. Holbrook, Jr. M. D.
Address Univ. Hosp. Date signed 1-26-46

G36822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1825

Registered No. G36822

Type or print the causes of death clearly and legibly. Physicians: please write the cause of death carefully. Important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Nebraska (b) County.....
(c) City or town Omaha,
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME FRANK JOSEPH WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No. Dimmed

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16 1893

8. AGE: Years	Months	Days	If less than one day
52	8	7	..... hr. ..... min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name John White
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Barrett
15. Birthplace Ireland

16 (a) Informant Livingston - Sondermann
(b) Address Home Home Grand Island Neb.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/27/46 (month) (day) (year)

(c) Cemetery or crematory.....
Location Grand Island Nebr

18 (a) Funeral director Williams & Duckworth Iowa
(b) Address Rock + Rumbyhomes Area

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1946, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 10th - 20th ? 1946 M.
(b) Where did injury occur? Freight car loaded at Cousel Bluff, Iowa
(c) Did injury occur at home, on farm, industrial place, in public place? Feight Car While at work? No
(d) Means of injury Suffocated in Freight Car Filled with grain.

23. Signature Robert Lee Eastman M.D.
Medical Examiner.

Date signed Jan. 24 1946

G36823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G36823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 Maryland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Maryland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel M. Doyle

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1881

8. AGE: Years 64 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Greenville Ga (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Knapp Shoe Co

FATHER
12. Name John M Doyle
13. Birthplace Ill

MOTHER
14. Maiden Name Ella McKee
15. Birthplace Ga

16 (a) Informant Mrs Margaret D Walther
(b) Address 270 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Co Md

18 (a) Funeral director Wilson Corbin Sons
(b) Address 1217 E Pratt St

19. JAN 28 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25/46 19 at 5:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Hemorrhage

Due to Pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 1/25/46

VS 151

G36824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 836

G36824 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 Bonaparte Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Emery

3 (b) If veteran, name war: N

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Emery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12. 1883

8. AGE: Years	Months	Days	If less than one day
62	3	13	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Dan K. Emery
(b) Address 1227 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Mowland Park
Location Baltimore Co Md

18 (a) Funeral director Gilbert & Son
(b) Address 1217 E Fayette St

19 (Date received by registrar) JAN 28 1946 Justice for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1946 to 1/25 1946 and that I last saw him alive on 1/25 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	12 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 1/25/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G368823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

G368823

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Colvert St
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Ingledue

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ira Ingledue

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) May 25, 1873

8. AGE: Years 72 Months 8 Days - If less than one day hr. min.

9. Birthplace Fredrick Co. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jonathan Myers
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Martin
15. Birthplace Md

16 (a) Informant Lillie Ingledue
(b) Address 940 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Co Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Baltimore St

19 (a) Filed JAN 29 1946 (b) Registrar Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Jan 1946 at 11 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1945 to Jan 25 1946 and that I last saw h.er alive on Jan 25 1945.

	Duration
Immediate cause of death: Coronary Thrombosis	2 hrs
Due to: Hypertension	10 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Edwin Muller M. D.

Address Date signed

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309 Registered No. 636826

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Hillen Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry G. Perring

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Catharine T. Perring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25th 1881

8. AGE: Years	Months	Days	If less than one day
64	9	0	hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)
10. Usual Occupation Harbor Engineer
11. Industry or business City of Balto.

FATHER
12. Name Henry C. Perring
13. Birthplace England

MOTHER
14. Maiden Name ? Allen
15. Birthplace Rhode Island

16 (a) Informant Brooks Perring (Son)
(b) Address 3304 Hillen Rd

17 (a) Cremation (b) Date thereof 1/28/46
(~~Burial~~, cremation, ~~or removal~~) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JAN 28 1946 (b) ~~Filed by~~ [illegible] M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1946, at 11 10 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Tamponade
Ruptured dissecting aneurysm
of Aorta

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grattan M.D.
Medical Examiner.
Date signed Jan. 25 1946.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 E Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2619 E Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn G. Finch

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1873

8. AGE: Years 72 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Stub
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary
15. Birthplace Md

16 (a) Informant James L Whitty
(b) Address Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1217 E Fort St

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Lurington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1946, at 11 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to 19, and that I last saw her alive on Jan 25 1946

Immediate cause of death: Cerebral hemorrhage — Duration 3 hrs.

Due to: Hypertension

Due to:

Other Conditions: Chronic hypertrophic arthritis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lane M. D.
Address 2607 Towson Date signed 1-26-46

VS 150

G36828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G36828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Old York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Deise

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband: Lewis F. Deise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar 15th 1865

8. AGE: Years	Months	Days	If less than one day
80	10	10	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Nurse's wife
11. Industry or business: at Home

FATHER
12. Name: John Reding
13. Birthplace: Md.

MOTHER
14. Maiden Name: Anna Wolff
15. Birthplace: Md.

16 (a) Informant: F. Miles Deise
(b) Address: 430 Clifton Park Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory: Balto.
Location: " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Interring for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1946, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1944, to Jan 25 1946, and that I last saw h.e.c. alive on Jan 22 1946

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M. H. Futterman M. D.
Address 7324 Reisterstown Rd Date signed 1/28/46

VS 150

THESE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G36829

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4321-N-Charles St.
(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4321-N-Charles St
(If rural give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella Shaw Warfield

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Emory W. Warfield
6 (c) If wife, give age ___ years

7. Birth date of deceased (mo., day, yr.) July 15 1861

8. AGE: Years 84 | Months 6 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none
11. Industry or business —

FATHER
12. Name George L Shaw
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Amelia Waldner
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Mildred W. Galey 2-(daughter)
(b) Address 4321-N-Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-46 (month) (day) (year)
(c) Cemetery or crematory Glenwood
Location Catonsville-Md.

18 (a) Funeral director Edward Mohn Co.
(b) Address 10 W Mt Royal Ave.

19 (a) JAN 28 1946 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to Jan 27 1946, and that I last saw her alive on Jan 26 1946.

Immediate cause of death: Heart failure with pulmonary Coma — Duration 5 days
Due to Chronic Hypertension — 20 years
Due to Heart Disease
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Gibson Porter M. D.
Address 4822 Roland Ave Date signed 1/27/46

VS 150

Dr Hepheinian ✓528 Rusk ave

G36830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G36830
Registered No.

Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. EVERY ITEM MUST BE FILLED, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1332 W. Lombard St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 1332 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda E. Schisler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. H. Schisler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 14-1864

8. AGE: Years	Months	Days	If less than one day hr.	min.
81	3	10		

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Joseph Van Daniker
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Tucker
15. Birthplace Md

16 (a) Informant Mr. Harry Schisler
(b) Address 1332 W Lombard St

17 (a) Burial (b) Date thereof Jan 28-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director Chas. L. Boyer Jr
(b) Address 1512 Hollins St

19 (a) JAN 28 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1946 at 11:08 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1945 to Jan 24, 1946, and that I last saw h[illegible] alive on Jan 22 1946.

Immediate cause of death Cachexia — Duration —

Due to Carcinomatosis — Duration —

Due to — Duration —

Other Conditions Rt. Hemiplegia
Hypostatic
(Include conditions contributing to death but not related to immediate cause of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Jeanette Heghinian M.D.
M.C.D.
Address 528 Rusk Ave Date signed 1/30/46

Jeanette Heghinian X

G36831 BALTIMORE CITY HEALTH DEPARTMENT G36831
CERTIFICATE OF DEATH 1340 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16da
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 GREENMOUNT AVE. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM DAMSKY
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 52 | Months ? | Days ? | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Shoe Repair
11. Industry or business

FATHER 12. Name Philip DAMSKY
13. Birthplace RUSSIA
MOTHER 14. Maiden Name Rachel
15. Birthplace RUSSIA

16 (a) Informant Rebecca Damsky
(b) Address 2110 Greenmount Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location
18 (a) Funeral director Jack Lewis Inc
(b) Address 1457 E Balto. St
19 JAN 28 1946 (b) Registrar
(Date rec'd by Local Registrar)
Huntington Williams, M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH 1-27 1946 at 3:55 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1946 to Jan 27 1946 and that I last saw h[illegible] alive on Jan 26 1946
Immediate cause of death Uremia — Duration
Due to Chronic pyelonephritis & nephrolithiasis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1-24-46
Major findings of operation: STONE in ureter, left (old rt. nephrectomy)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gayle D Arnold M.D.
Address 4. M. H. Date signed 1-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS 150

G36852 BALTIMORE CITY HEALTH DEPARTMENT X V G36852

CERTIFICATE OF DEATH 46F

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE BLACK INK. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Rugatia Ave
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Bess B. Hartle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Own Home

FATHER
12. Name Frank Barr
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Mallotte
15. Birthplace Maryland

16 (a) Informant Mrs Helen Zito
(b) Address

17 (a) Removal (b) Date thereof 1/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hagerstown Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) JAN 28 1946 Registrar
(Date received by registrar)

Thurlington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1946, at 10:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1946, to Jan 27 1946, and that I last saw her alive on Jan 27 1946.

	Duration
Immediate cause of death Cardiac decompensation	Jan 26
Due to abdominal carcinomatosis	?
Due to	
Other Conditions	post

(Include pregnancy within 3 months of death)
Date of operation Jan 26, 1946
Major findings of operation: Abdominal carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry W. Limp M. D.
Address Mercy Hosp Date signed 1/27

VS 150

G36853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Home for Incurables 700 W. 40th St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harry G. Kesler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1867

8. AGE: Years	Months	Days	If less than one day
78	8	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Office Assistant

11. Industry or business

FATHER
12. Name Emanuel P. Kesler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Charlotte Wade
15. Birthplace Baltimore, Md.

16 (a) Informant Home for Incurable records
(b) Address 700 W. 40th St. Baltimore 11, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Washington Millimore, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946, at 8.48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1940 to Jan. 25 1946 and that I last saw h-- alive on Jan. 25 1946

Immediate cause of death	Duration
Pneumonia (Bronchial)	2 days
Due to	
Due to	
Other Conditions Multiple Arthritis Deformans, Chronic (Include pregnancy within 3 months of death)	18 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St Baltimore 11 Md. Date signed 1/25/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36834 — 93D — Registered No. G36834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Cliffburn Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mr. Charles Henry Deetz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1864

8. AGE: Years	Months	Days	If less than one day
81	9	17	hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Mr. Thomas Deetz
13. Birthplace Penn.

MOTHER — 14. Maiden Name Caroline Nace
15. Birthplace Penn.

16 (a) Informant hospital records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1946 at 8 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1946, to Jan. 27 1946, and that I last saw him alive on Jan. 27 1946.

Immediate cause of death	Duration
pulmonary edema	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Snyder, Jr.
Address Union Memorial Hospital Date signed 1/27/46 M.D.

VS 150

G36855

BALTIMORE CITY HEALTH DEPARTMENT ✓ G36855

CERTIFICATE OF DEATH 742

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT and SARATOGA Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4729 Park Heights Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** JUDITH MARION BERMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	Child

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH-30-1942

8. AGE: Years	Months	Days	If less than one day
3	9	28	hr. min.

9. Birthplace Baltimore Md (Town, County, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Harry Berman
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Ann Levin
15. Birthplace Baltimore, Md

16 (a) Informant Hospital Records
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 46 (month) (day) (year)
(c) Cemetery or crematory Anshei Emunah Cemetery
Location Washington Blvd

18 (a) Funeral director L. L. Levinson & Bro.
(b) Address 1124-26 N. North Ave

19 (a) JAN 29 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 19 46 at 5:10 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 19 46 to 1-27 19 46.
and that I last saw h[illegible] alive on 1-27 19 46.

Immediate cause of death	Duration
Cardio-Respiratory Failure	2 hrs. approx
Due to Sub-acute lymphatic Leukemia (Aleukemic)	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E Kirk M. D.
Address Mercy Hospital Date signed 1-27-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462 Registered No. 636836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 East 3rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 East 3rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Gutman

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14. 1863

8. AGE: Years 82 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Grocery man

11. Industry or business Dry

FATHER 12. Name John B Gutmann
13. Birthplace Germany

MOTHER 14. Maiden Name Dorothy Hohlman
15. Birthplace Germany

16 (a) Informant Caroline D'Hole
(b) Address 924 E 3rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director William Col Inc
(b) Address 1217 St Paul St

19 (a) JAN 28 1946 (Date rec'd by Registrar) for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 30 1945 to Jan. 26 1946 and that I last saw him alive on Jan. 26 1946

Immediate cause of death: Cancerous Colon — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl H Benson M.D.
Address 5111 York Rd Date signed Jan 27 1946

VS 150

636837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 636837

Type or write with PERMANENT BLACK INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1251 Dellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1251 Dellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie R Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	nne

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife A mon S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1860

8. AGE: Years	Months	Days	If less than one day
85	5	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Noah B Grimes
13. Birthplace Md

MOTHER
14. Maiden Name Amanda Mattingley
15. Birthplace Md

16 (a) Informant Elsie M Cates
(b) Address 1251 Dellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden Baltimore Md

18 (a) Funeral director Wilbur Cook Co
(b) Address 1214 W Cold St

19 (a) JAN 28 1946 (Date filed by registrar) Huntington Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946 at 8:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 to Jan 26 1946 and that I last saw her alive on Jan 26 1946

Immediate cause of death	Duration
Left Cerebral Hemorrhage	
Cerebro-renal Vascular Disease	2 yrs
Due to	
Due to Myocardial Insufficiency	1 day
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J W Wilcox M. D.
Address 617 W. 40th St Date signed 1/26/46

636838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

750

636838 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5240 York Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5240 York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Weber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella Nora Weber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1866

8. AGE: Years 79 | Months 6 7 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Gasoline Station Operator

11. Industry or business

FATHER 12. Name Weber
13. Birthplace Unknown

MOTHER 14. Maiden Name Bruewer
15. Birthplace Unknown

16 (a) Informant Mrs. Ella Nora Weber
(b) Address 5240 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28/46. (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Randallstown, Md.

18 (a) Funeral director Harry H. Little
(b) Address 401 E. Monument Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946, at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Jan 23 1946 and that I last saw him alive on Jan 23 1946.

	Duration
Immediate cause of death: Acute Cardiac Dilatation	Sudden
Due to Obstruction Tumor Mass - Intraabdominal	More than 4 years
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert Sardo M. D.
Address 5839 York Rd Date signed 1/25/46

G36839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1220 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Byrd

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife Willie Byrd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1893

8. AGE: Years	Months	Days	If less than one day
52	11	21	hr. min.

9. Birthplace Winnsboro, S.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sam Wilson
13. Birthplace S.C.

MOTHER
14. Maiden Name Mariah Carr
15. Birthplace S.C.

16 (a) Informant Willie Byrd
(b) Address 1220 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cemetery
Location Arbutus

18 (a) Funeral director Elroy O. Wilson
(b) Address 1100 Bland Lane

19 (a) (b) Registrar

Date received by Local Registrar JAN 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to Jan 26 1946 and that I last saw her alive on Jan 26 1946

Immediate cause of death Bronchial Pneumonia — Duration 4 days

Due to

Due to

Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. T. Watt
Address 515 N. Arlington Ave Date signed 1/27/46

correct age is especially important. Physicians: please write the ... Every item of information should be carefully supplied. The ... the causes of death clearly and legibly.

G36840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1270

Registered No. G36840

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 Etting St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Etting St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Whalen Harris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/10/1915

8. AGE: Years	Months	Days	If less than one day
30	6	14 15	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Whalen
13. Birthplace Md.

MOTHER
14. Maiden Name Hattie
15. Birthplace Md

16 (a) Informant Henrietta Young (Sister
(b) Address 1823 Etting St.

17 (a) Burial (b) Date thereof 1/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant View
Location Doubs, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) JAN 28 1946 (b)
(Date filed by registrar) Registrar

Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25/46 19.... at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18/ 1946 to 1/25/ 1946, and that I last saw h[illegible] alive on 1/24/ 1946.

Immediate cause of death [illegible] Duration
Peritonitis
Due to [illegible] Gall bladder
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1300 N. [illegible] Date signed 1/26/46
M. D.

G36811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G36811 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Huntingdon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Huntingdon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Walters.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Frederick J. Walters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1873

8. AGE: Years	Months	Days	If less than one day
72	9	4	hr. min.

9. Birthplace California
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Jackenberg
13. Birthplace California

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. Bernadine Slaylor
(b) Address 2802 Huntingdon Ave.

17 (a) Burial (b) Date thereof Jan 30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615 Chestnut Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 28 1946 Huntington Williams, M.F.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1946, at 7.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 00 1944 to Jan 27 1946 and that I last saw h er alive on Jan 27 1946

Immediate cause of death Chronic Myocarditis

	Duration
Due to	
Due to	
Other Conditions Arteriosclerosis & Chronic Nephritis	indefy

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Dr. Huntington
Address 1120 W. 20th Date signed Jan. 28. 46

X

G36812 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G36812

CERTIFICATE OF DEATH 1826

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Nebraska (b) County
(c) City or town Omaha,
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JAMES WOODS

3 (b) If veteran, name war

3 (c) Social Security Account No. 012-14-7939

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Belle White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Brooklyn - New York
(Town, county, and state)

10. Usual Occupation Laborer on R.R.

11. Industry or business

FATHER
12. Name James Woods
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Beagan
15. Birthplace Prince Edward Isle

16 (a) Informant Mrs Mary Bloomer - Sister
(b) Address 467 Main St. Watertown Mass

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Jan 30-46 (month) (day) (year)
(c) Cemetery or crematory Saint Patricks
Location Watertown Mass

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 JAN 28 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1946, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 10th ? at 20th ? 1946 M.
(b) Where did injury occur? Freight car loaded at Cousel Bluff, Iowa
(c) Did injury occur at home, on farm, industrial place, in public place? Freight Car While at work? No
(d) Means of injury Suffocated in Freight Car Filled with grain.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 24 1946

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G36843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G36843 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 West Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Sadie M. Conley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 4-1905

8. AGE: Years 40 | Months 5 | Days 21 | If less than one day hr. min. 12

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Patrick Conley

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Ann Dooley

15. Birthplace Ireland

16 (a) Informant Josephine M. Conley

(b) Address 1614 W. Balto St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-46 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto Md

18 (a) Funeral director Thomas J. Kenny Inc.

(b) Address Hollins & Fulton

JAN 28 1946 (Date rec'd by registrar)

(b) Huntington Mill Assistant U.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1946, at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1946 to 1-26 1946, and that I last saw her alive on 1-26 1946

Immediate cause of death Burns - 2 & 3 degree — Duration 6 days

Due to

Due to

Other Conditions Uremia due to renal Insufficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/1

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 1-20-46 at 4 30 P M

(c) Where did injury occur? Balto. Md.
Bon Secours (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? Yes
(Specify type of place)

(e) Means of injury Dress ignited from kitchen stove

23. Signature Richard C. Hayden M. D.

Address Bon Secours Date signed 1-26-46

Approved by Cpt Lubinski MD

G36814 BALTIMORE CITY HEALTH DEPARTMENT G36814

CERTIFICATE OF DEATH

13/a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Jones

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Col.	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/3/1892

8. AGE: Years	Months	Days	If less than one day
54	-	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Alex Richards
13. Birthplace Maryland

MOTHER
14. Maiden Name Julia ?
15. Birthplace Maryland

16 (a) Informant Dorothy Johnson
(b) Address 727 Greenmount ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. Co.

18 (a) Funeral director Haynes Sanders
(b) Address 1412 E Preston Street

19 (a) (Filed) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27/46 19 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20/46 to 1/27/46 19
and that I last saw h— alive on 1/26/46

Immediate cause of death Pneumonia — Duration 7 days
Due to Lobar Pneumonia — Duration
Due to Nephritis — Duration
Due to — Duration
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 724 Mad Ave Date signed 1/29/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

G36845 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Entire life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice F. Duvall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Elnora Duvall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25/1898

8. AGE: Years	Months	Days	If less than one day
47 48	8	1	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Joseph Duvall
13. Birthplace Maryland

MOTHER
14. Maiden Name Ambie Owens
15. Birthplace Maryland

16 (a) Informant Elnora Duvall
(b) Address 1310 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Gdns
Location Arbutus, Maryland

18 (a) Funeral director Laynes & Sanders
(b) Address 1412 E. Preston Street

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1946 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1946 to 1-26 1946 and that I last saw him alive on 1-26 1946

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to hypertension & arteriosclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Henry M. D.
Address Univ. Hosp. Date signed 1-26-46

VS 150

G36846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G36846

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 Calvert
(c) Hospital or institution: The Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 N Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Charles Hamilton Carey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 2, 1874
8. AGE: Years 71 | Months 3 | Days 25 | If less than one day hr. min. 1968
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Thomas Irwin Carey
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Martha Leiper
15. Birthplace Pennsylvania

16 (a) Informant Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/46 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Balto Md

18 (a) Funeral director Henry H Jenkins Sons
(b) Address McCulloh & Orchard Sts

19 (a) JAN 28 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1946, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1946, to Jan 27 1946, and that I last saw him alive on Jan 27 1946.

Immediate cause of death Cerebral Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Hayden B. Arnold M. D.
Address U.M.H. Date signed 1-27-46

VS 150

G36847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G36847

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Susan D. Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Edward S. Tyler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1869

8. AGE: Years	Months	Days	If less than one day
76	3	10	hr. min.

9. Birthplace Berlin Worchester Co, Md (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name Dr. James C. Dirickson
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza B. Cummings
15. Birthplace Md

16 (a) Informant Ed. S. Tyler
(b) Address 829 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Balto Co Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1937, to Jan 25 1946, and that I last saw h.... alive on Jan 26, 1946.

Immediate cause of death Coronary occlusion — Duration 7 yrs 3 months

Due to Cerebro sclerosis

Due to

Other Conditions Pernicious anaemia — 6 months

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard M. D.
Address 12 E. Eager St Date signed Jan 27, 46

VS 150

G36848

G36848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Wyndhurst Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County B
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Wyndhurst Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME MARION GERTRUDE STANSBURY FENHAGEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife James Conn Fenhagen
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Sept 7 1875

8. AGE: Years	Months	Days	If less than one day
70	4	19	..... hr. ..... min.

9. Birthplace Milwaukee, Wisconsin
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Hamilton Stansbury
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Martha Follin
15. Birthplace Maryland

16 (a) Informant James C. Fenhagen
(b) Address 2 Wyndhurst Ave. Balto. Md.

17 (a) Burial (b) Date thereof Jan 28 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) JAN 28 1946 (b) Huntington, W. Va.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1946 at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31/39 19..., to 1/26/46 19..., and that I last saw her alive on 1/26/46 19...

Immediate cause of death	Duration
Carcinomaof the rt. breast with metastases to the rt. lung	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jarvis M.D.
Address 11 E. Chase St., City Date signed 1/26/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

579

G36849 Registered No.

Please write the causes of death clearly and legibly. The accuracy of this certificate is especially important. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 Orleans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. Sherian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1942

8. AGE: Years	Months	Days	If less than one day
3	10	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name William Sherian
13. Birthplace N. C.

MOTHER
14. Maiden Name Dorothy Peters
15. Birthplace N. C.

16 (a) Informant Dorothy Sherian
(b) Address 1834 Orleans St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-30-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto

18 (a) Funeral director Walter B. Scriggs
(b) Address 138 W. Hamburg St.

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) by the signature of Williams III Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1946, at 2 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebello-pontine Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Jan. 27 1946.

VS 151

46850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G36850 Registered No.

Every item of information should be carefully supplied. PERSONS WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 S. Norris St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 S. Norris St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Harrison Fauble

3 (b) If veteran, name war	3 (c) Social Security Account No. 705-05-6740

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary F. Fauble
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 15, 1888

8. AGE: Years	Months	Days	If less than one day
57	6 5	25 10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Folding Machine Operator
11. Industry or business B & O RR Printing

FATHER
12. Name Joshua Fauble
13. Birthplace United States

MOTHER
14. Maiden Name Laner Constantine
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary F. Fauble
(b) Address 317 S. Norris St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Memorial
(b) Address 1003 W. Baltimore St.

JAN 28 1946 (Date rec'd by registrar) per Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1946, at 5.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1946 to 1-25 1946 and that I last saw him alive on 1-25 1946

Immediate cause of death Subarachnoid hemorrhage — Duration 4 days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature M. Boldrey, M. D.
Address 54 S. Fulton Ave. Date signed

VS 150

X

G36851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G36851

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2342 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Pierre Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-13-46

8. AGE: Years	Months	Days	If less than one day
	1	5 Weeks 2	..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Charles Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Evelyn Boley
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan 28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mo. Robert G. Ellis & Son
(b) Address 1129 N. Caroline St

19 (a) 1-28-1946 (b) Huntington Williams Md
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-1946 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1946 to 1-25 1946, and that I last saw h. alive on 1-25 1946.

Immediate cause of death	Duration
Congenital Heart disease	
Due to.....	
Due to.....	Several
Other Conditions.....	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Walter M. Tarson M.D.
Address J.H.H. Date signed 1-26-46

X

JL - 23575 G36852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G36852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 15
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 S. Stockton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife Bessie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1882

8. AGE: Years	Months	Days	If less than one day
63 64	3	6	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ruben Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Julia Johnson
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30, 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location
18 (a) Funeral director Wm Kelly R. Dillon
(b) Address 322 W. Lexington St. Baltimore, Md.
JAN 28 1946 (Date filed by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1946 at 7:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14 1945, to Jan. 26 1946, and that I last saw h im alive on Jan. 26 1946

	Duration
Immediate cause of death: Uraemia	2 wks
Due to: Pyelonephritis	4 mos
Due to: CARCINOMA of bladder with metastasis	10 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-11-45
Major findings of operation: CA of bladder
of autopsy: Same above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address Balto. City Hosp. Date signed 1-27-46

VS 150

G36853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

G36853 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 W Fairmount Ave
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace alexander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race B

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1931

8. AGE: Years 14 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Daniel Alexander
13. Birthplace Virginia

MOTHER
14. Maiden Name Rosa
15. Birthplace Virginia

16 (a) Informant Rosa Alexander
(b) Address 1529 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1946 (month) (day) (year)

(c) Cemetery or crematory
Location Mt. Auburn Cem.

18 (a) Funeral director Wm. Ralph Phillips
(b) Address 3229 W. Lanvale St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JAN 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1946 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1946, to 1-24 1946, and that I last saw h. alive on 1-24 1946

Immediate cause of death: Left heart Ventricular failure

Due to rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D.S. Gray M. D.

Address 1 mi N Date signed 1-25-46

X

G36854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G36854 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Smith

3 (b) If veteran, name war I

3 (c) Social Security Account No. –

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1900

8. AGE: Years 45 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Raleigh, N. C.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace N. C.

MOTHER
14. Maiden Name –
15. Birthplace –

16 (a) Informant Mrs. Bessie Smith
(b) Address 816 W. Franklin St.

17 (a) Burial (b) Date thereof Jan. 29 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location

18 (a) Funeral director Mrs Kate R. Killigrew
(b) Address 822 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151 JAN 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-1946, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-25-46

Please write the causes of death clearly and legibly. Physicians: please write the cause of death as especially important. Please write the cause of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

636855 636855

CERTIFICATE OF DEATH ✓ 92B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 N. Gay St. 4-V St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 39 yrs. 10 mos. 25 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Angelina Theresa Battaglia

If U. S. Veteran specify WAR.

(a) Residence: No. 1607 North Gay St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Battaglia

6. DATE OF BIRTH (month, day, year) March 5-1906

7. AGE	Years	Months	Days 25	If LESS than 1 day ___ hrs. or ___ min.
	39	10		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) 12-7-46

11. Total time (years) spent in this occupation 2 Yrs

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME Salvatore Ferdinando

14. BIRTHPLACE (city or town) (State or country) Italy

MOTHER

15. MAIDEN NAME Antonietta Jeffe

16. BIRTHPLACE (city or town) (State or country) Italy

17. INFORMANT John Battaglia

(Address) 1607 N. Gay St

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Redeemer Date 1/31 1946

19. UNDERTAKER Clarence F. Hoffman

(Address) 1639 N. Broadway

20. FILED ..... 19.....

JAN 28 1946 Huntington Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) January 28, 1946

22. I HEREBY CERTIFY, That I attended deceased from January 2 1946 to January 28 1946

I last saw h[illegible] alive on January 20 1946 Death is said to have occurred on the date stated above, at 12 59 P. M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Rheumatic Fever	
Stenosis + Insufficiency	1934
Aortic Stenosis + Insufficiency	

Other contributory causes of importance:

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

..... If so, specify .....

(Signed) W. Norton Wiesinger M. D.

(Address) 714 Medical Arts Bldg.

X

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

6368 MD

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 S. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Conrad

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-1481

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary K. Hetzner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1877

8. AGE: Years	Months	Days	If less than one day
68	9 10	4 27	hr. min.

9. Birthplace Australia (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Canton Lumber Co.

FATHER
12. Name George Conrad
13. Birthplace Australia

MOTHER
14. Maiden Name Barbara Yek
15. Birthplace Australia

16 (a) Informant Mary K. Conrad
(b) Address 935 S. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) JAN 28 (b) 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946, at 1:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1946, to Jan 24 1946, and that I last saw him alive on Jan 24 1946

Immediate cause of death	Duration
Gastro Intestinal hemorrhage	
Due to Esophageal and Gastric varices	
Due to Cirrhosis of Liver	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lorraine B. Hartzler M. D.
Address Sinai Hospital Date signed 1-24-46

Huntington Pharmacy

124 B

G36857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 36857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3717 Eastern Ave.
(c) Hospital or institution: 2669
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie K. Booth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John T. Booth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1884

8. AGE: Years	Months	Days	If less than one day
61	4	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Herman Stintz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary A. Mohr
15. Birthplace Baltimore

16 (a) Informant John T. Booth
(b) Address 3717 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) JAN 28 1946 (b) (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945 to Jan 24 1946 and that I last saw h[illegible] alive on 1/24 1946.

Immediate cause of death: Apoplexy — Duration 2 hrs.
Due to Arteriosclerotic Cardio vascular Disease. — Duration 4 yrs.
Due to Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lucius E. Lattle M. D.
Address 10 W. Madison St. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63685 8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

63685 3

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fenden & Madison
(c) Hospital or institution:
Maryland General Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE ELIZABETH HOLMES

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John M. Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	1	hr. min.

9. Birthplace Louisville, Ky.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles S. Blanche
13. Birthplace France

MOTHER
14. Maiden Name Florence Cobb
15. Birthplace Georgia

16 (a) Informant Mrs. Donald Lang
(b) Address 3306 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 20 [illegible] Balto., Md.

19 (a) JAN 23 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1946, at 2.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1946, to 1-26 1946, and that I last saw her/ alive on 1-26 1946.

Immediate cause of death	Duration
Peripheral Vascular collapse	
Due to Carcinoma of breast c Metastasis to thoracic spine	
Due to and resulting paralysis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Grace E. Jones M. D.
Address Md General Hospital Date signed 1/26/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

72a

Registered No. G36859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 Woodington Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CECELIA E. BENNER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Conrad Henry Benner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 16, 1871

8. AGE: Years: 74 | Months: 9 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Emil Erni
13. Birthplace: Germany

MOTHER
14. Maiden Name: Bertha ?
15. Birthplace

16 (a) Informant: Mrs. Edward Rummel
(b) Address: 807 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 28 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1946 at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Jan 26 1946 and that I last saw here alive on Jan 26 1946.

	Duration
Immediate cause of death: Rectal hemorrhage	2 days.
Due to: Puerperum hemorrhagica	4 days
Due to:	
Other Conditions: Arteris-sclerosis	15 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. C. Wells M. D.
Address 4101 Edmondson Ave. Date signed 1/26/46

X

636860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 84a

636860 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (Towson)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7345 Yorktowne Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard S. Davies, Jr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-44

8. AGE: Years	Months	Days	If less than one day
1	3	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Howard Davies Sr.
13. Birthplace Columbus, Ohio

MOTHER
14. Maiden Name Barbara B. Ball
15. Birthplace Columbus, Ohio

16 (a) Informant Howard S. Davies, Sr.
(b) Address 7345 Yorktowne Drive Towson

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946, at 10:00 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mongolian (Idiocy)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-26-46

VS 151

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH ONE PADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36861 Registered No. 47c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Wyanoke Ave.
(c) Hospital or institution: 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Wyanoke (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM S. QUINN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie G. Quinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1883

8. AGE: Years	Months	Days	If less than one day
62	2	1	hr. min.

9. Birthplace Pocomoke, Md. (Town, county, and state)
10. Usual Occupation Insurance Agt.
11. Industry or business North American Acc. Ins. Co.

FATHER
12. Name Wm. W. Quinn
13. Birthplace Pocomoke, Md.

MOTHER
14. Maiden Name Mary Clark
15. Birthplace Pocomoke, Md.

16 (a) Informant Mrs. Annie G. Quinn
(b) Address 606 Wyanoke Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory Sunnyside
Location Crisfield, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 28 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 JAN. 1946, to 27 JAN. 1946, and that I last saw him alive on 27 JAN 1946

Immediate cause of death	Duration
Bronchogenic Carcinoma of	
Due to left lung	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave. Date signed 28 Jan 46

VS 150

63682 · BALTIMORE CITY HEALTH DEPARTMENT · 6 copies 63682

CERTIFICATE OF DEATH

Registered No. 172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and the town)
(d) Street No. 18 S. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Frank Michniewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theresa Michniewicz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 16 1895

8. AGE: Years: 50 | Months: 5 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Longshoreman

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Poland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Poland

16 (a) Informant: Mrs. Theresa Michniewicz
(b) Address: 18 S. Patterson Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 29 46 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary Cem
Location: Baltimore County

18 (a) Funeral director: John M. Weber
(b) Address: 401 S. Chester street

19 (a) JAN 28 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25th 1946, at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractures skull

Due to:

Other Conditions: Bronchio-pneumonia, Epidemic hemorrhagic

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/10/46 at 7:30 P.M.
(b) Where did injury occur? Pier #3 Canton
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury: Fell 30 ft into hold of ship.

23. Signature: Howard A. Mudd M.D.
Medical Examiner.
Date signed 1-26-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6368:3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

6368:3 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden and Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Fayette Ave #24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michelena Stanislawski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 83 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Francis Stanislawski
(b) Address 2621 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Germantown Hill Md

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) JAN 28 1946 (Registered by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1946 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30/1945 to 1/27/1946 and that I last saw her alive on 1/27/1946

Immediate cause of death	Duration
Ruptured vascular collapse	
Due to Left cerebral hemorrhage	
Due to La Grippe	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzales
Address Maryland General Hospital signed M.D. 1/27/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36864

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G36864
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Hudson St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Hudson St.
(If rural give location)
(e) Citizen of foreign country? ~~Yes~~ No)
If yes, name country

3 (a) FULL NAME Thomas C. Arthur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 60 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Arthur
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Gardner
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Arthur
(b) Address 2811 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John F. Duda
(b) Address 2829 Hudson St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

JAN 28 1946

Use ink

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1946 at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1943 to 1/26 1946 and that I last saw h~~im~~ alive on 1/25 1946.

Immediate cause of death Hypertensive Cardio Vascular disease

Due to (As Stated Above)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mitchell F. Rountree M. D.

Address 1016 S. East Ave Date signed 1/26/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √13a

636865 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 BELWOOD AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs, 6 mos. 4 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 BELWOOD AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FRISINO, WARREN NICHOLAS

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-2755

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWED

6 (b) Name of husband or wife VIRGINIA CATHERINE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/22/1900

8. AGE: Years	Months	Days	If less than one day
45	6	4	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation MUSICIAN, MUSIC TEACHER
11. Industry or business MUSIC TEACHING

FATHER
12. Name BENJAMIN FRISINO
13. Birthplace FORENZA, ITALY

MOTHER
14. Maiden Name ANTONETTE JUNE
15. Birthplace FORENZA, ITALY

16 (a) Informant brother: Thomas G. FRISINO
(b) Address 2318 Aisquith St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-30-46 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD, BALTIMORE, Md.

18 (a) Funeral director LEO COOK
(b) Address PATTERSON PK AVE, BALTIMORE

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 26 1946, at 7 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946, to 1/26 1946, and that I last saw him alive on 1/26 1946

Immediate cause of death UREMIA — Duration 4 days.

Due to HYPERTENSIVE CARDIO-RENAL DISEASE — Duration 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Nesbitt, M.D.
Address 6919 HARFORD Rd Date signed 1/26/46

X

636866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

636866 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 Warner Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore 20 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Warner Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annabelle Holley Jackson Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Edward Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 23 1909

8. AGE: Years	Months	Days	If less than one day
36	1	4	hr. min.

9. Birthplace Chester South Carolina
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Bud Holley

13. Birthplace Chester South Carolina

MOTHER 14. Maiden Name Dinah Smalls

15. Birthplace Chester South Carolina

16. (a) Informant Edward Walker Husband

(b) Address 713 Warner Street

17 (a) Removal (b) Date thereof Jan. 31, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Chester South Carolina

Location Chester County

18 (a) Funeral director Joseph A. Sizely

(b) Address 1400 Mount Street

19 (a) JAN 28 1946 (b)
(Date rec'd by registrar) Huntington Williams Health Officer

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1946, at 12 P.M. 45

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1946 to 1/27 1946, and that I last saw h[illegible] alive on 1/26 1946.

Immediate cause of death Acute Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 1111 Lee Date signed 1/28/46

VS 3

G36867 BALTIMORE CITY HEALTH DEPARTMENT X G36867
Registered No.

CERTIFICATE OF DEATH 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Harrisonburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 3
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman McDonaldson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-29-14
8. AGE: Years 31 Months 5 Days 29 If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name Benjamin McDonaldson
13. Birthplace Va

MOTHER 14. Maiden Name Mamie Armstrong
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28-1946 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Harrisonburg Va.

18 (a) Funeral director Manuel C. Dyer
(b) Address 1600 W. North Ave.

JAN 28 1946 (a) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1946 at 2:00 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1946 to Jan 27 1946 and that I last saw him alive on Jan 27 1946.

Immediate cause of death	Duration
Uremia	
Due to Ureteral occlusion	
Due to Recurrent carcinoma of Colon	
Other Conditions Polyposis of colon Rheumatic heart disease	

(Include pregnancy within 3 months of death)
Date of operation May 1945
Major findings of operation: Carcinoma of recto-sigmoid
of autopsy Recurrent carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Richard F. Kuffler Jr. M.D.
Address JHH Date signed 1/27/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G36868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G36868 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY C. MERRYMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John J. Merryman
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Ohio.

16 (a) Informant Henry Merryman
(b) Address 822 W. Fayette St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8/46 19 to 1/22 19 46, and that I last saw h alive on 1/22/46 19

Immediate cause of death Cerebral Hemorrhage
Antecedent

Due to Cer. Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Barnes
Address Univ. Hosp. Date signed 1/24/46

VS 150

3267 Thomas J. Barnes M.D.

G36869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G36869 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Brickhammer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name No relatives
13. Birthplace

MOTHER
14. Maiden Name no relatives.
15. Birthplace

16 (a) Informant Came in by Accident room
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 28 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1946 to 1-20 1946, and that I last saw h[illegible] alive on 1-20 1946.

Immediate cause of death	Duration
Resp. obst and bron chopneumonia	
Due to Adenocarcinoma undetermined location	
Due to	
Other Conditions Syphilis.	

(Include pregnancy within 3 months of death)

Date of operation None except
Major findings of operation: a biopsy taken from neck - adenocarcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas E. Bradshaw M. D.
Address Univ. Hosp. Date signed 1/28/46

VS 150

5266

G36870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G36870

N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Green
(c) Hospital or institution: Univ. Hosp. 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Green (Greene)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/12/46

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John T Green
13. Birthplace

MOTHER
14. Maiden Name Odessa Richardson
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 28 1946 (Date rec'd by registrar) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1946, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1946 to 1/21 1946, and that I last saw h[illegible] alive on 1/21 1946.

Immediate cause of death	Duration
Gastric Hemorrhage	
Due to hemorrhagic disease of newborn (?)	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Univ Hosp. Date signed 1/ M.

E 8205

161 C

G36871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G36871

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward + Bene
(c) Hospital or institution:
Univ. Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Joyce Hotel Pratt 2
2135 Eastern (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Kirk Rogers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Tenn. (Town, county and State)
10. Usual Occupation Hospital aid
11. Industry or business

FATHER
12. Name James Rogers
13. Birthplace Tenn

MOTHER
14. Maiden Name Mary G. Willis
15. Birthplace Tenn.

16 (a) Informant Kirk Rogers.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address
19 JAN 28 1946 By direction of Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21 1946, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1946, to 1-21 1946, and that I last saw h[illegible] alive on 1-21 1946.

Immediate cause of death	Duration
Edema + acidosis	
Due to Nephritis	
Due to Cardiovascular-renal disease - Rheumatic -	
Other Conditions Dehydration + exhaustion + carcinoma	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George P. Callender M. D.
Address Univ. Hosp. Edward St. Date signed 1-26-46

VS 150

15264

X

[redacted] G36872 BALTIMORE CITY HEALTH DEPARTMENT [redacted]

CERTIFICATE OF DEATH

Registered No. 1278 G36872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument St.
(c) Hospital or institution: Sinai Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. EAGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James T. Eagan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1894.

8. AGE: Years	Months	Days	If less than one day
51	4	5	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James B. Barron
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Sheppard
15. Birthplace Md.

16 (a) Informant Mr. James T. Eagan
(b) Address 205 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Tuttle
(b) Address 4101 Edmondson Ave.

19 (a) 1946 (b) Filed by registrar Lexington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946 at 1 18 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1946 to 1-26 1946, and that I last saw her alive on 1-26 1946.

Immediate cause of death	Duration
Hepatic damage	
Due to Choledocholithiasis	
Due to	
Other Conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: as above, C dilatation of common bile duct
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Stanburn M.D.
Address Sinai Hospital Date signed 1/26/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G36873

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1946

[redacted] Registered No. G36873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilbens r Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balti. 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2694 St. Benedict's
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Maggie Reich
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~ single
6 (b) Name of husband or wife
6 (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) 12/29/1872
8. AGE: Years 73 | Months - | Days 28 | If less than one day hr. min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Reich
13. Birthplace Germany

MOTHER
14. Maiden Name Dora
15. Birthplace Germany

16 (a) Informant Mrs Geo. M. Shipley
(b) Address 1908 Kennard Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md
18 (a) Funeral director F. B. Wappert Son
(b) Address 650 W. Baltimore St
19 (a) (Date rec'd by registrar) (b) Registrar

VS 106 JAN 28 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1946 at 7:15 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1946 to 1/27 1946, and that I last saw h[illegible] alive on 1/27 1946.

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Chronic Arteriosclerotic Cardiac Disease	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Cuthbert T. Hall Jr. M. D.
Address St. Agnes Hosp. Date signed 1/27/46

X

G36874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G36874

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Darby St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Darby St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Kerns

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Joseph A. Kerns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1884

8. AGE: Years	Months	Days	If less than one day
61	1	15	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name Robert Fletcher
13. Birthplace Va

MOTHER
14. Maiden Name Lucy J Hall
15. Birthplace Va

16 (a) Informant Betty M Ward
(b) Address 929 E 32d St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 1/31/46 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden - Baltimore Md

18 (a) Funeral director Hilborn Cook Inc
(b) Address 1217 N Paul St

19 (a) JAN 29 1946 (Date rec'd by registrar) (b) Huntington for Williams H.F. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1945 to Jan 27 1946 and that I last saw h.e alive on Jan 27 1946.

Immediate cause of death: Arteriosclerotic CVD
Due to: Decompensation — Duration 2 yr.
Due to:
Other Conditions: Diabetes Mellitus — Duration 2
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Laurence Flamant M. D.
Address 5711 Falls Rd Date signed 1-28-46

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. G36875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9/9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Argyle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Connor

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie C. Connor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 19 1865

8. AGE: Years: 80 | Months: 3 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Alexandria Va.
(Town, county, and state)

10. Usual Occupation: Plumber Retired

11. Industry or business:

FATHER
12. Name: Jerry Connor
13. Birthplace: Bermuda

MOTHER
14. Maiden Name: Elizabeth White
15. Birthplace: Bermuda

16 (a) Informant: Charles M Connor
(b) Address: 212 Kentucky Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory: Balto.
Location: " Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) JAN 29 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1946 at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractures of Skull; Multiple fractures of Ribs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-26-46 at 7:40 P.M. 9/9
(b) Where did injury occur? Augusta & Olivia Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Pedestrian struck by auto

23. Signature: Robert L. Gratacap M.D.
Medical Examiner.
Date signed Jan 27 1946

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G368,6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G368,6 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Solgist of
(c) Hospital or institution South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 S Hanover St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Francis C. Meyers

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-1909

8. AGE: Years 36 37 yrs. | Months 6 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name Fred. W. Meyers
13. Birthplace Germany

MOTHER
14. Maiden Name Rosie Long
15. Birthplace Md.

16 (a) Informant Bessie Meyers
(b) Address 117 S. Hanover St

17 (a) Burial (b) Date thereof 1/31/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 29 1946 (b) by Mrs. for Williams M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28-46 19 ..., at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1946 to 1-28 1946 and that I last saw h[illegible] alive on 1-28 1946

Immediate cause of death	Duration
Pulmonary tuberculosis	8 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address ABCH Date signed 1-29-46

VS 150

G36817

BALTIMORE CITY HEALTH DEPARTMENT

TN. 98790

CERTIFICATE OF DEATH

108

G36817 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

154

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mabel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21st 1900

8. AGE: Years	Months	Days	If less than one day
45	5	5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jordon
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Jan 29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Ux Brooks
(b) Address 463 N. Carey St

19 (a) JAN 29 1946 Huntington Williams Hsp
(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26th 1946 at 9.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24th 1946 to Jan. 26 1946 and that I last saw him alive on Jan. 26th 1946

Immediate cause of death (a) Coma
Pneumonia
and Lung abscess

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address 2 E 16 Date signed 1/26/46

VS 150

G36878 BALTIMORE CITY HEALTH DEPARTMENT X G36878

CERTIFICATE OF DEATH 58B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Mo-28 da
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Mo-28 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County A.A.Co.
(c) City or town Eastpoint (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Second Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Evelyn Mae Dwyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Robert R. Dwyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1901

8. AGE: Years 44 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Wapun, Wisconsin (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hardrink
13. Birthplace

MOTHER
14. Maiden Name Jennie Munson
15. Birthplace DeKalb Illinois

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown R. Balto Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-29-46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. City

18 (a) Funeral director STEWART & BROWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) (Date received by registrar) JAN 29 1946 Huntington Pittsburgh, Pa. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946, at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945 to Jan 27 1946, and that I last saw her alive on Jan 27 1946

	Duration
Immediate cause of death: Vegetative endocarditis	8 mo.
Due to: rheumatic fever	
Due to: Schizophrenia hebephrenic type	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward P. Allaga M. D.
Address 336 Frederick Ave Date signed 1-29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G36879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Leopold

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife (Single)

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-23-1864

8. AGE: Years 81 | Months 5 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Harrisonburg Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Lewis Leopold
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Strick
15. Birthplace Harrisonburg Va

16 (a) Informant Statement of Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-46 (month) (day) (year)
(c) Cemetery or crematory Woodbine
Location Harrisonburg Va.

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W Franklin Ave.

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams Registrar

JAN 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28 1946 at 3:34 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946, to 1/28 1946, and that I last saw her alive on 1/28 1946.

Immediate cause of death CARDIAC FAILURE — Duration 14 DAYS

Due to HCVD

Due to

Other Conditions HEART BLOCK

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart Jr. M. D.
Address M. G. H. Date signed 1/28/46

X

636830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43a Registered No. 636830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4400 Greenspring Ave
(c) Hospital or institution:
LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Freidel Scherr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years: 86 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Edith
15. Birthplace Russia

16 (a) Informant abe Goldstein
(b) Address 1617 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-46 (month) (day) (year)
(c) Cemetery or crematory Har Israel
Location Northern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 629 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 29 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1933, to 1-26 1946 and that I last saw h[illegible] alive on 1-28 1946.

Immediate cause of death	Duration
Cerebral hemiplegia	1-21-46
Hypertension, Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Kern M.D.
Address Levindale Date signed 1/28/46

G36831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G36831 Registered No.

AB-97277

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jim Georgalos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16- 1886

8. AGE: Years 59 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Tony Georgalos (D
13. Birthplace Greece

MOTHER
14. Maiden Name Famie ? (D
15. Birthplace Greece

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/46 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Woodlawn Mall Road

18 (a) Funeral director [illegible] Funeral Home Inc.
(b) Address 420 E. North Ave

19 (a) [illegible] by [illegible] Huntington Williams, M.D. Registrar
JAN 29 1946

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Jan. 26 1946 at 10.37 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1945 to 1-26 1946 and that I last saw him alive on 1-26- 1946

Immediate cause of death Pulmonary Tuberculosis — Duration 4 Yrs.

Due to

Due to

Other Conditions Cardiac failure - Etiology ? - Double Pelleteus - (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy Pulmonary tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Dawson M. D.
Address B. C. H. Date signed 1/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36832 ✓ G36832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1145 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Coleman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1876

8. AGE: Years 69 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Nash. N. C. (Town, county, and state)

10. Usual Occupation Piano Tuner

11. Industry or business

FATHER 12. Name Alexander Coleman

13. Birthplace Alexandria, Va

MOTHER 14. Maiden Name Mary R. Jones

15. Birthplace Louisiana

16 (a) Informant Mary A. Coleman

(b) Address 1145 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29 1946 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Co.

Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Hilland

(b) Address 1631 Druid Hill Ave.

19 (a) JAN 29 1946 (b) Registrar

Thursday

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1946 at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to Jan 25 1946 and that I last saw ... alive on Jan 25 1946.

Immediate cause of death — Duration

Arteriosclerosis — 9 Mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts

Address 754 Edmondson Ave. Date signed 1/29/46 (M. D.)

VS 150

G36833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G36833
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 263 Easter St
(If rural give location)
(e) Citizen of foreign country? East Indies (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rita Apicella

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/45

8. AGE: Years	Months	Days	If less than one day
	1	14 10	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alphonse Apicella
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Marie Miciello
15. Birthplace Baltimore Maryland

16 (a) Informant Alphonse Apicello
(b) Address 263 Easter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-1946 (month) (day) (year)
(c) Cemetery or crematory Mount Holy Redeemer Cem
Location 4430 Belair Road

18 (a) Funeral director Joseph Tarace Sons
(b) Address 2043 Greenmount Ave

19 (a) JAN 29 1946 (Date rec'd by Reg'r) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1946, at 11:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1946, to 1-28 1946, and that I last saw her alive on 1-28 1946.

Immediate cause of death Medical shock — Duration

Due to Subdural distension

Due to Intermittent obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Congenital cord

of autopsy: Congenital encephalocele

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Mace M. D.
Address Univ. Hosp. Date signed 1-28-46

X

G36884

AB-98234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G36884

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Clayton

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Christina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13- 1871

8. AGE: Years	Months	Days	If less than one day
74	10	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name HEZEKI CLAYTON
13. Birthplace Md.

MOTHER
14. Maiden Name HENRIETTA GIBSON
15. Birthplace Md.

Baltimore City Hospitals Records

16 (a) Informant
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof JAN. 29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE.

18 (a) Funeral director Tilly & Zaiden Inc.
(b) Address 403 S. WOLFE ST.

JAN 29 1946
(Date rec'd by Registrar)

(b) Huntington Wilkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1946 at 8.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1946 to 1-26- 1946 and that I last saw him alive on 1-26- 1946

Immediate cause of death: cerebrovascular accident — Duration

Due to

Due to

Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: not yet available

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Amatteau Rowland M. D.

Address B C H Date signed 1/28/46

83a

VS 150

G36885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. G36885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Warmer St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Warmer (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George David Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-45

8. AGE: Years	Months	Days	If less than one day
	4 5	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name George David Sr
13. Birthplace S. C

MOTHER
14. Maiden Name Earline Johnson
15. Birthplace S. C

16 (a) Informant Geo. David Sr
(b) Address 1114 Warmer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location L. A. B. Md

18 (a) Funeral director Isaiah T. Brown Jr
(b) Address 106 N Montgomery St

19 (a) JAN 29 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946, to Jan 27 1946, and that I last saw h[illegible] alive on Jan 26 1946.

Immediate cause of death Acute Nephritis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. D. Jay Jr
Address 222 Harlem Ave, Date signed 1/28/46

X

G36886

AB-94109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G36886

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos- 16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Pearle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1914

8. AGE: Years	Months	Days	If less than one day
31	6	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Baker (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Henry
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-46
(month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto City

18 (a) Funeral director Daniel L. Brown & Son
(b) Address 1 E. W. Montgomery St.

JAN 29 1946
(Date rec'd by registrar) Registrar of Vital Statistics

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1946 at 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 1945 to 1-27 1946 and that I last saw h im alive on 1-27 1946

Immediate cause of death: Tuberculoma of Brain-
Due to: Tuberculosis of Brain
Due to:
Other Conditions: Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Duration
>
-

Date of operation
Major findings of operation:
of autopsy: Gross

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert H. Copeland Jr M. D.
Address Balt. City Hosp. Date signed 1/27/46

VS 150

G36887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G36887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 S Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 S Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie Andersson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife B. F. Andersson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1867

8. AGE: Years 79 | Months - | Days 12 | If less than one day hr. min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Soren
13. Birthplace Denmark

MOTHER 14. Maiden Name Unknown
15. Birthplace Denmark

16 (a) Informant B. F. Andersson
(b) Address 17 S Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director John A Moran
(b) Address 3600 E Baltimore St

19 (a) [illegible] (b) Huntington Williams, M.D.
(Date rec'd by registrar) JAN 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1946 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Jan 27 1946, and that I last saw her alive on Jan 27 1946

Immediate cause of death Myocardosis — Duration

Due to Hypertensive heart disease

Due to Essential hypertension

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Gould M. D.
Address 14X East Ave Date signed 1-29-46

636838

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

61

Registered No. 636838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address 1620 N. Bond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Shore Acres Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Akers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph R. Akers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Hagerstown Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name L. Downin
13. Birthplace ?

MOTHER
14. Maiden Name Annie
15. Birthplace ?

16 (a) Informant Joseph R. Akers
(b) Address 1620 N. Bond St

17 (a) Burial (b) Date thereof Jan 30 - 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Frederick Rd

18 (a) Funeral director Bernard Hanle
(b) Address 121 E. West St

19 (a) JAN 29 1946 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1946 at 4 P M

21. I certify that I took charge of the remains described above, held an Inquest in Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Luchinsky M.D.
Medical Examiner.
Date signed 1/27/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36839
48297

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G36839
Registered No.

CERTIFICATE OF DEATH 157a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Emmitsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt - 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Lee Sharrer.

3 (b) If veteran, name war ns
3 (c) Social Security Account No. ns

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-45

8. AGE: Years | Months: 4 | Days: 9 | If less than one day: hr. min.

9. Birthplace Emmitsburg Md. Frederick Co
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Marshall Sharrer
13. Birthplace Md

MOTHER
14. Maiden Name Pauline Valentine
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Taylor Cemetery
Location Rocky Ridge Md

18 (a) Funeral director M. L. Creager Son Thurmont Md
(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

VS JAN 29 1946

Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan 28 1946 at 5:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1946, to Jan 28 1946, and that I last saw him alive on Jan 25 1946

Immediate cause of death: Respiratory failure — Duration

Due to Increased intracranial pressure

Due to Non-communicating hydrocephalus

Other Conditions after III Ventriculostomy
(Include pregnancy within 3 months of death)

Date of operation 1/26/46

Major findings of operation: non-communicating hydrocephalus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard E. Dorsett M. D.
Address Johns Hopkins Hosp. Balto Date signed 1/28/46

X

G36890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G36890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Canterbury Rd.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Canterbury Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE WILLIAM RIFE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Frances S. Rife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1861

8. AGE: Years 84 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Commercial Banker
11. Industry or business: Retired

FATHER
12. Name: John S. Rife
13. Birthplace

MOTHER
14. Maiden Name: Sarah
15. Birthplace

16 (a) Informant: Mr. George Walter Rife
(b) Address: 331 E. University Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 30 1946 (b)
Received by registrar Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH: Jan. 28, 1946, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1942 to Jan 28 1946 and that I last saw him alive on Jan 28 1946

Immediate cause of death: Acute Pulmonary Edema
Secondary to Coronae
Due to Stone
Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Geraghty
Address 3047 N. Calvert St. Date signed 1/28/46

Huntington Williams, M.D.

GERAGHTY

G36891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36891 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2952 W. North Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2952 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LAURENCE E. JENKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Grace Belle Jenkins
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 21, 1879

8. AGE: Years	Months	Days	If less than one day
67	0	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation City Highway Inspector
11. Industry or business City of Baltimore

FATHER
12. Name Robert Jenkins
13. Birthplace England

MOTHER
14. Maiden Name Rachael R. Warfield
15. Birthplace Md.

16. (a) Informant Mr. Ralph L. Jenkins
(b) Address 1914 Englewood Ave., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Jan. 28, 1946, at 5:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945 to Jan 28 1946 and that I last saw h alive on Jan 27 1946

Immediate cause of death	Duration
Chronic cardio vas.	10 yrs
Due to disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ernest R Lakin
Address 1735 Poplar Ct Date signed 1/29/46 M. D.

VS 150

JAN 29 1946 Washington Millians M.D.

X

G36892
487244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G36892
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Summers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-44

8. AGE: Years	Months	Days	If less than one day
1	9	18	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Summers
13. Birthplace Wash. D.C.

MOTHER 14. Maiden Name Rosa Gresham
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1-30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 29 1946
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 28 1946 at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1946 to Jan. 28 1946 and that I last saw him alive on Jan. 28 1946.

Immediate cause of death Pregnant
Respiratory failure — Duration

Due to increased intracranial pressure

Due to Tuberculous meningitis

Other Conditions Miliary tuberculosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard E. Dorman M. D.

Address Johns Hopkins Hosp. Balto. Date signed 1/28/46

Amending for Pneumonia

X

G36893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G36893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 769 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy McClellan

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-16-0887

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Annie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1901
8. AGE: Years 45 Months Days If less than one day hr. min.
9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Crawford
13. Birthplace S.C.

MOTHER
14. Maiden Name Rosetta Howell
15. Birthplace S.C.

16 (a) Informant Alena Grant
(b) Address Mullins, S.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-45 (month) (day) (year)
(c) Cemetery or crematory Dillon
Location South Carolina

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) JAN 29 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1946 at 11:55 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Liver;
Ascites, Jaundice

Due to

Other Conditions Chronic pulmonary Tuberculosis bilateral;
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slaton M.D.
Medical Examiner.
Date signed Jan. 23 '46

VS 151

1243

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G36894 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1539 Penna ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 Penna ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Weldon L Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-21-1902

8. AGE: Years	Months	Days	If less than one day
43	1	5	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Garry Williams
13. Birthplace Va

MOTHER
14. Maiden Name Maggie Williams
15. Birthplace Va

16 (a) Informant Garry Williams
(b) Address 1539 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 30 46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Arbutus Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) (Date rec'd by registrar) (b) Lexington Williams M.D.

JAN 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946, at 5 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945 to 1-26 1946 and that I last saw h— alive on 1-26 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Eisenberg M. D.
Address 805 N Fremont Date signed 1-29-46.

X

636895

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 85

636895
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Beach Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aline Olsen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Olaf R. Olsen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19–1909

8. AGE: Years	Months	Days	If less than one day
36	4	7	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christoffer Christofferson
13. Birthplace Norway

MOTHER
14. Maiden Name Alma Milhoran
15. Birthplace Germany

16 (a) Informant Olaf R. Olsen
(b) Address 2 Beach Drive, Dundalk, Md.

17 (a) Burial (b) Date thereof Jan. 29-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem.
Location O'Donnell St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) JAN 28 1946 (b) Huntingtown, Md.
(Date received by registrar)
JAN 29 1946
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1946, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Status epilepticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward Lee Fortune M.D.
Medical Examiner.
Date signed Jan 27 1946.

...age is especially important. Physicians: please write the ...causes of death clearly and legibly.

G36896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √161C

G36896 Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write all information asked for carefully and completely.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. of A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or county write RURAL and give town)
(d) Street No. 502 Norris St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brenda Cooper

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Infant

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/1945

8. AGE: Years	Months	Days	If less than one day
	3	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name William Cooper
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice Drumwright
15. Birthplace Baltimore, Md.

16 (a) Informant Alice Cooper (Mother).
(b) Address 502 Norris St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County Md.

18 (a) Funeral director Charles C. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) JAN 29 1946 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1946, at 9:20 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Erythroblastosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed Jan 26 1946

G36897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G36897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland S.W.C.
(b) Street address Charles & Center Sts.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. James Apts., Chas. & Center St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah P. Walton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Robert Walton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Edward J. Penniman
13. Birthplace Balto.

MOTHER
14. Maiden Name Naomi Gosnell
15. Birthplace Balto.

16 (a) Informant Mrs. Mary P. Purvis
(b) Address 6101 Maywood Ave.

17 (a) Burial (b) Date thereof 1/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Greenmount
Location North & Greenmount Aves

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1906 Eutaw Place

19 (a) Jan 30 1946 Certificate for Pulmonary
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Jan 28 1946
and that I last saw her alive on Jan 26 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration 10 Yrs

Due to

Due to

Other Conditions Pulmonary Hemorrhage — 1 Day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Kavanagh M.D.
M. D.
Address 3328 McElderry St. Date signed 1-29-46

VS 150

G36893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G36893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 E. Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Burnett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-1903

8. AGE: Years	Months	Days	If less than one day
42	11	10	hr. min.

9. Birthplace Carven Co. N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name Lunetta Chapman
15. Birthplace Carven Co. N.C.

16 (a) Informant Thatten Davis
(b) Address 100 E. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-46 (month) (day) (year)
(c) Cemetery or crematory
Location Greenville, N.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Bunting Ave

19 (a) JAN 29 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1946 at 5 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of right Breast with extensive metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Jan 29 1946

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36899 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N. Curley St
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Curley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude Becker
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Mar 16 1866

8. AGE: Years	Months	Days	If less than one day
79	10	11	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Becker
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Stein
15. Birthplace Germany

16 (a) Informant Mrs. Carl Becker
(b) Address 602 N. Mason St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-46 (month) (day) (year)
(c) Cemetery or crematory Emanuel Cem
Location Gregory Ave
18 (a) Funeral director John C. Melly Inc
(b) Address 2405 E. Pratt St
19 (a) JAN 22 1946 (Date received by registrar) (b) Lexington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to 1/27 1946 and that I last saw h alive on 1/26 1946

Immediate cause of death	Duration
Coronary Thrombosis	last
Due to Chronic Myocarditis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dr. Wright D. Ryder M. D.
Address 3373 E. Baltimore St Date signed 1/27/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36900

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 46E

G36900 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Madison
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Salonia Travers

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Lake Travers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Elizabeth Saunders
15. Birthplace --

16 (a) Informant Mr. Norman L. Travers
(b) Address 1925 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)
(c) Cemetery or crematory Madison Church Cem.
Location Madison

18 (a) Funeral director K. R. THOMAS
(b) Address Crisfield, Md.

JAN 29 1946 (Date received by registrar) (b) Burial Permit

Huntington Williams

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Jan. 29, 1946, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov, 1945 to Jan 29 1946 and that I last saw h[illegible] alive on Jan 28 1946

Immediate cause of death Carcinomatosis
of Large Intestine
With general Carcinomatosis
Due to Carcinoma

Due to

Other Conditions General Debility

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: –

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro M. D.
Address 2028 Eastern Pl. Date signed 1/29/46

VS 150

X

G36901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 147

G36901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 William Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 William Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD A. STRAUSS SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
------	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Annie J. Edeleman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1890

8. AGE: Years	Months	Days	If less than one day
55	6	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name John Strauss
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Beidebach
15. Birthplace Maryland

16 (a) Informant Family
(b) Address 1708 William Street

17 (a) Burial (b) Date thereof 1/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie, Maryland

18 (a) Funeral director James L. McCully
(b) Address 130 E. Fort Ave.

19 (a) JAN 29 1946 (b) Huntington for Wilkinson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1946, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Jan 27 1946, and that I last saw him alive on Jan 26 1946

	Duration
Immediate cause of death Cardiac Thrombosis	12hr
Due to Leukemia Chronica	1yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 1/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G36902 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4626 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4626 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE AGNES COFFEY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59	-	-	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business Fine Fur Company

FATHER
12. Name Timothy Coffey
13. Birthplace Ireland

MOTHER
14. Maiden Name Marie Comack
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine Smith
(b) Address 4626 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) JAN 29 1946 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26th 1946, at 5:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Jany 26 1946 and that I last saw h[illegible] alive on Jany 26 1946.

Immediate cause of death

Duration

Carcinoma left
Due to Breast (Recurrent)
Due to Metastasis to left
Other Conditions Lung Pleura

(Include pregnancy within 3 months of death)

Date of operation February 1945
Major findings of operation Radical for Carcinoma Breast
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F J Kirby M. D.
Address 110 E Northern Ave Date signed 1/28/46

VS 150

G36903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

G36903

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 N. Bradford St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Cepl, Sr. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife (nee Vanura): Barbara Cepl

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.) 7/15/87

8. AGE: Years 58 | Months 6 | Days 13 | If less than one day: hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Sparrows Point, Md.

FATHER
12. Name John Cepl
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Charles Cepl Jr
(b) Address 924 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) JAN 29 1946 (Date rec'd by registrar) (b) [illegible] Registrar

VS Form JAN 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28 1946, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 1946 to 1/28 1946 and that I last saw him alive on 1/28 1946

Immediate cause of death: Cardio-Respiratory failure — Duration

Due to Bilateral pneumonia

Due to Emphysema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Emphysema, Bilateral pneumonia, Old

of autopsy: Hypostasis present

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Cepl Jr

Address St Joseph's Hosp Date signed 1/29/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36904 94a

Registered No. G36904

G36904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 H
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N Belnard Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME Leonard Nieberline (Neiberline)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of ~~husband~~ or wife Tillie (nee Nigrin)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1888

8. AGE: Years	Months	Days	If less than one day
57 yrs.	9	26	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business United Fruit Company

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Otilia Neiberline - wife
(b) Address 820 N. Belnord Avenue

17 (a) JAN 29 1946 (Burial, cremation, or removal) (b) Date thereof 1/31/46 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Oak Lawn
Location 7225 Eastern Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street Huntington Williamsport

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

JAN 29 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 January 1946 12:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

25. Signature William S. Heffner M.D.
Medical Examiner

Date signed 28 January 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G36905 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caymen + Dukeland
(c) Hospital or Institution Md. Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Asa Pittman

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 213-10-1456

4. Sex: M.
5. Color or race: White
6 (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: Margaret T. Pittman
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 22, 1895
8. AGE: Years: 50 | Months: 8 | Days: 7 | If less than one day: hr. min.
9. Birthplace: Virginia (town, county, and state)
10. Usual Occupation: Operator
11. Industry or business: Baltimore Transit Co.

FATHER
12. Name: Henry Pittman
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Lucy Talley
15. Birthplace: Virginia

16 (a) Informant: Margaret Pittman
(b) Address: 2817 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. (month) (day) 1946 (year)
(c) Cemetery or crematory: Western
Location: Baltimore Maryland

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) 1946 Feb 4 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 January 1946, at 8:38 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Dec 1945 to 29 Jan 1946 and that I last saw h[illegible] alive on 29 Jan 46

Immediate cause of death: Cer. Failure — Duration
Due to: Myocardial Infarction
Due to: Coronary Occlusion
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Lester G. Stacey M. D.
Address: B.B.S.H. Date signed: 2/4/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 89a

Registered No. G36906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Mfg.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Rural - Fallston
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Leonard Daughton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence M Daughton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April - 28 - 1919

8. AGE: Years	Months	Days	If less than one day
26	9	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Electrical Contractor
11. Industry or business

FATHER
12. Name Charles M Daughton
13. Birthplace Md.

MOTHER
14. Maiden Name Lena Daughton
15. Birthplace Md.

16 (a) Informant Florence M Daughton
(b) Address Fallston - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 1946 (month) (day) (year)
(c) Cemetery or crematory Jarrettsville Cemetery
Location Jarrettsville Md
18 (a) Funeral director E. J. Rust & Son
(b) Address Jarrettsville Md
19 (a)

JAN 29 1946

Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1946, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June - 12 - 1946, to June - 29 - 1946 and that I last saw h.. alive on June - 29 1946.

Immediate cause of death	Duration
Brain Abscess	
Due to Chronic Mastoiditis	
Due to Chronic Otitis Media	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Brain Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Johnson M. D.
Address Date signed 1/29/46

G36907 BALTIMORE CITY HEALTH DEPARTMENT G36907
CERTIFICATE OF DEATH 186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3527 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? S (Yes or No)
If yes, name country

3 (a) FULL NAME Norbert V. Mullen (MULLEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1888

8. AGE: Years 57 | Months 7 6 | Days 19 | If less than one day hr. min.

9. Birthplace Emmitsburg Md.
(Town, county and state)

10. Usual Occupation Retired Mechanic

11. Industry or business

FATHER
12. Name James Mullen
13. Birthplace Maryland

MOTHER
14. Maiden Name S Robenateel
15. Birthplace Maryland

16 (a) Informant Mrs. Dora Mullen
(b) Address 3527 Belvedere Ave.

17 (a) Burial (b) Date thereof 1/30/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem
Location Balto. City.

18 (a) Funeral director C. Vernon Lonnigan
(b) Address 4611 Park Heights

19 (a) JAN 29 1946 (b)
(Date Rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946, at 8:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture
Subdural Hemorrhage

Due to

Other Conditions Coronary sclerosis, moderate.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 26 1946 10:30 P M
(b) Where did injury occur? 3527 Belvedere Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down cellar steps

23. Signature Benedict Skotarelis M.D.
Medical Examiner.
Date signed 1-28-46.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

636908 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 Moreland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 8
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Moreland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Greenbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
76 75			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Max Greenbaum
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Mollie Greenbaum
(b) Address 1719 Moreland Ave

17 (a) Burial (b) Date thereof Jan, 30, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Local registrar) (b) Huntington Hitchcock

JAN 30 1946

VS 150

MEDICAL CERTIFICATION 11.30

20. DATE OF DEATH January 29 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1946 to Jan 29 1946 and that I last saw h[illegible] alive on Jan. 29 1946

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Hypertensive Cardio-Vascular Disease	?
Due to Embolized & thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip J. Lerner
Address 2401 N. North Ave. Date signed 1/29/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G36903 ✓ G36903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Juanita McKittrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John McKittrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1889

8. AGE: Years	Months	Days	If less than one day
56	8	2	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Jack True
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John McKittrick
(b) Address 1008 E. Federal St

17 (a) Balto (b) Date thereof 2/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1946, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946 to Jan 28 1946, and that I last saw h[illegible] alive on Jan 27 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Hemiplegia	
Due to Subarachnoid hemorrhage	
Other Conditions Generalized arteriosclerosis & hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 601 N. Monroe St Date signed 1/29/46

636910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

636910

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 DX
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Bernard J. McCauley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband~~ or wife: Alice V. McCauley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19th 1870

8. AGE: Years 76 | Months 0 | Days 10 | If less than one day hr. min.

9. Birthplace Glenn Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Farmer

FATHER
12. Name Bernard J. McCauley
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Elmina Woodall
15. Birthplace Kent Co. Md.

16 (a) Informant Nicholas Sennett
(Address) 2414 Register Ave-Rodgers Forge

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof Feb 1st 1946
(month) (day) (year)

(c) Cemetery ~~or crematory~~ Chestertown
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) JAN 30 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1946 at 8:30 AM

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Auto-accidental C.V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelhemke M.D.
Medical Examiner.
Date signed 1/29/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

Huntington Williams, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G36911 — BALTIMORE CITY HEALTH DEPARTMENT — G36911 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 Whitridge
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Whitridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. McCarriar

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: ———

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James McCarriar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1860

8. AGE: Years 85 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Elliott Combs
13. Birthplace Md

MOTHER
14. Maiden Name Lydia Hunter
15. Birthplace Md

16 (a) Informant Mary Connelly
(b) Address 337 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1st 1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18. (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 30 1946 (b) (Date rec'd by registrar) Registrar

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1946, at 5:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26, 1946, to Jan. 27, 1946, and that I last saw her alive on Jan. 27, 1946.

	Duration
Immediate cause of death: Chronic Myocarditis	Unknown.
Due to: Unknown.	
Due to: "	
Other Conditions: None.	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St. Date signed Jan. 28, 46

VS 150

X

G36912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

X G36912 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Calvert
(c) Hospital or institution: The Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Boyce ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Leo Joseph Nous

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irene McShane Nous

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	17	hr. min.

9. Birthplace Missouri (Town, county, and state)

10. Usual Occupation Executive

11. Industry or business

FATHER 12. Name Henry Nous

13. Birthplace Germany

MOTHER 14. Maiden Name Dorthy Bates

15. Birthplace Kentucky

16 (a) Informant Joseph M. Nous

(b) Address Boyce Ave. - Towson

17 (a) Removal (b) Date thereof 1/30/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Calvary - St. Louis

Location Missouri

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 (a) (b)
(Date received by local registrar) Registrar

JAN 30 1946

VS 150

Huntington Williams, Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946, at 2:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1946 to Jan 27 1946 and that I last saw h[illegible] alive on Jan 29 1946.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Jones M.D.

Address Union Mem. Hosp Date signed 1/29/46

X

G36913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G36913

CERTIFICATE OF DEATH

$3a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (~~year, month or~~ days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundle
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marley Heights
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Klehm

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Louise Klehm
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 27 1882

8. AGE: Years	Months	Days	If less than one day
63	6	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business FOR SELF

FATHER
12. Name Henry Klehm
13. Birthplace ? BALTO. MD.

MOTHER
14. Maiden Name ? UNKNOWN
15. Birthplace ? BALTO. MD.

16 (a) Informant LOUISE KLEHM (WIFE)
(b) Address MARLEY HEIGHTS GLEN BURNIE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 1/46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Tilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) JAN 30 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JAN. 29 1946 at 11/58 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 1946 to 1/29 1946 and that I last saw h.I.M. alive on 1/29 1945

Immediate cause of death Cerebral Hemorrhage — Duration 2 days
Due to Hypertension — ?
Due to
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex B. Kelly Jr. M. D.
Address Mercy Hosp Date signed 1/29

VS 150

G36914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G36914 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 Amity St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days).
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Amity St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Boston

3 (b) If veteran, name war
3 (c) Social Security Account No. 213-12-2224

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 1896

8. AGE: Years 49 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Boston
13. Birthplace Md.

MOTHER 14. Maiden Name Annie Morgan
15. Birthplace Md.

16 (a) Informant Mattie Jones
(b) Address 210 Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 30 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1946 at 5:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27-1946 to 1-28 1946, and that I last saw him alive on 1/26 1946.

Immediate cause of death: Uremia Cardio Renal Disease — Duration 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 N. Eden St. Date signed

G36915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G36915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 S. Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Walter Jankowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212 03 4312

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Estelle Jankowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22 1902

8. AGE: Years	Months	Days	If less than one day
43	9	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Service Manager
11. Industry or business Garden

FATHER
12. Name Joseph Jankowski
13. Birthplace Poland (Prussia)

MOTHER
14. Maiden Name Agnes Budzwoski
15. Birthplace Poland Prussia.

16 (a) Informant Estelle Jankowski
(b) Address 607 S. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozaguski
(b) Address 1930 Eastern Ave.

JAN 30 1946 (b) (Date Received by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946 at 2.15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1946 to Jan 28 1946, and that I last saw him alive on Jan 28 1946.

Immediate cause of death Acute Dilation Heart. (Duration: Few Hours) 1-17-46

Due to Cerebral Hemorrhage. (Duration: to 1-28-46)

Due to

Other Conditions Uremia Coma Paralysis, Left side. (Include pregnancy within 3 months of death) 1-17-46

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Graham Marston M. D.
Address 516 Cathedral St Date signed 1-29-46.

X over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G36916 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Leo Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Theresa E. Holland / Holland | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1881

8. AGE: Years 64 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Sea-food Dealer

11. Industry or business

FATHER
12. Name John G Holland
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Barbey
15. Birthplace Maryland

16 (a) Informant Mr. John L. Holland
(b) Address 1602 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

JAN 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946 at 3:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1945, to Jan 29 1946, and that I last saw him alive on Jan 29 1946

	Duration
Immediate cause of death: Cardio-Respiratory Failure	2 Days
Due to	
Due to	
Other Conditions: Carcinoma of the Pancreas	

(Include pregnancy within 3 months of death)

Date of operation Jan. 26, 1946

Major findings of operation: Inoperable carcinoma of the Pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P. M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Lamy Sanchez M.D.
Address Mercy Hospital Date signed 1/29/46

SANCHEZ

G36917 BALTIMORE CITY HEALTH DEPARTMENT G36917
CERTIFICATE OF DEATH 170C Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3832 Ednor Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Wolf, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Marie Elizabeth Wolf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1877

8. AGE: Years	Months	Days	If less than one day
68	2	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Daniel Miller & Co.

FATHER
12. Name Charles H. Wolf
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Georgianna Snyder
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Marie E. Wolf
(b) Address 3832 Ednor Rd.

17 (a) Burial (b) Date thereof 1/31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams
(Date rec'd by registrar) Registrar

JAN 30 1946

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946 at 2 P. M. 50

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intra cranial hem-
orrhage.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24-46 at 9/1 M.
(b) Where did injury occur? Greenmount & 39th St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury ~~a fall from a street car~~ struck by Motor Vehicle

23. Signature Benedict F. Sturla M.D.
Medical Examiner.
Date signed Jan 29, 1946.

(over)

X

636913 BALTIMORE CITY HEALTH DEPARTMENT 94a Reg. 636913

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Monticello
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Monticello (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecile A. JACKSON

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edwin R.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept. 19, 1895.
8. AGE: Years 50 | Months 4 | Days 9 | If less than one day hr. min.
9. Birthplace: Pickway, Ohio (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William Wootton
13. Birthplace: Canada

MOTHER
14. Maiden Name: Alameda Potts
15. Birthplace: Canada

16 (a) Informant: Dr. Edwin R. Jackson
(b) Address: 2309 Monticello Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory
Location: Syracuse, N. Y.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams (Registrar)

JAN 31 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/46 19 at 7.25 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to NR death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. (Medical Examiner.)
Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 636919

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Sharp
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Thomas

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lottie Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 60 | Months | Days | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Henry Thomas
13. Birthplace W. Va.

MOTHER
14. Maiden Name Catherine Twyman
15. Birthplace W. Va.

16 (a) Informant Lottie Thomas
(b) Address 609 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar
JAN 30 1946 Certificate for Publication

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1946 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 1/28 1946 and that I last saw him alive on 1/25 1946

Immediate cause of death Cerebral Hemorrhage

Due to arterio sclerosis Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1118 W Lee Date signed 1/29 (M. D.) /46

X

G36920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36920

Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County Bergen
(c) City or town Wallendale & Mahwah
(If outside city or town limits, write RURAL and give town)
(d) Street No. Forest Road R. F. D.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva May Strong

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertie F. Strong

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec. 21-1880

8. AGE: Years 65 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hopper.
13. Birthplace N. J.

MOTHER
14. Maiden Name Margaret Yeomans.
15. Birthplace N. J.

16 (a) Informant Mrs Jennie Strong
(b) Address Mahwah Township N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-46 (month) (day) (year)

(c) Cemetery or crematory Wyckoff Cem
Location Wyckoff N. J.

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Hollins St

19 (a) JAN 30 1946 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH January 28, 1946; at 7 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture
Fracture of 6th rib, right and left ribs, 4, 5, 6 & 7.

Other Conditions Compound fracture of patella
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-28-46 at Howard Ave. A. M.
(b) Where did injury occur? Elkridge & West. Blvd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. by auto. collision

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 1-29-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Items of information should be carefully supplied. The

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. G36921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5200 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town paltimre
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5200 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HATTIE ELIZABETH RICE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Gustavus Rice.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1872

8. AGE: Years: 73 | Months: 4 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Rowland Archer
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden Name: Emma Hunter
15. Birthplace: Harford Co., Md.

16 (a) Informant: Mrs. John W. Klees - Daughter
(b) Address: 5200 pelair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-46 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

JAN 30 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1946, at 9.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1945, to Jan 28 1946, and that I last saw h-er alive on Jan 28 1946.

Immediate cause of death	Duration
Carcinoma of Intestines	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scognetta M. D.
Address 724 E Lombard St Date signed 1/29/46

VS 150

X

G36922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G36922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Wilson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-46

8. AGE: Years	Months	Days	If less than one day
			hr. 53 min.

9. Birthplace Franklin Square Hospital (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Wilbur Wilson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Scheidgger
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emma Wilson
(b) Address 1505 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Pitt & Co. D. M. Walker
(b) Address Pitt & Stricker Sts.

19 JAN 30 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29- 1946, at 8:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1946 to 1-29 1946 and that I last saw her alive on 1-29 1946

Immediate cause of death: Respiratory Failure — Duration 53 min.
Due to
Due to
Other Conditions Premature - 32 weeks
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter W. Krengel M.D.
Address Franklin Square Hosp. Date signed 1-29-46

G36923 new

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G36923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Lanvale ST. 15
(c) Hospital or institution: Bon Secours Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 26 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3753 Columbus Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hoffmann

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-46

8. AGE: Years	Months	Days	If less than one day
		1	26 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry John Hoffmann
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Helen Murphy
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof Jan 30-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Md

18 (a) Funeral director Edward F. Kenna
(b) Address 3911 Liberty Heights Ave
19 (a) JAN 30 1946 (b) Signature for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH 1-29 1946, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1946, to 1-29 1946 and that I last saw h.c.c. alive on Jan 28 1946.

Immediate cause of death	Duration
Premature birth	26 hrs.
Due to Separation of Placenta	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 4710 Elbert Pl. Date signed 1/30/46

VS 3

636924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. 636924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 N. Stricker (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reginald Cheney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-94

8. AGE: Years	Months	Days	If less than one day
51	11	9	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Thomas A Cheney
13. Birthplace Md

MOTHER 14. Maiden Name Mabel Jackson
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-46 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md Balto Co.

18 (a) Funeral director Bryon Bros. & Wm. H. Haigh
(b) Address 421 Aisquith St

JAN 30 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1946 at 2 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1946 to Jan 26 1946 and that I last saw him alive on Jan 26 1946.

	Duration
Immediate cause of death Uremia	7 days
Due to Bilateral pyelo-nephritis	4 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan L Lewis M.D.
Address Johns Hopkins Hosp Date signed 1-29-46

G36925 Ph McCargill

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G36925 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 538 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 N. Bond St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Joseph Parker
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1865 March 3

8. AGE: Years	Months	Days	If less than one day
80	10		hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Diggs Parker
13. Birthplace Va

MOTHER
14. Maiden Name Mildred McDonney
15. Birthplace Va.

16 (a) Informant Ellen Hall
(b) Address 538 N Bond St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Md
18 (a) Funeral director Robert Williams
(b) Address 1515 McElderry St
19 (a) ..... (b) ..... (Date received by local registrar) Huntington for Williams M.D.

JAN 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1946, at 11:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 1-24-1946, to 1-28-1946, and that I last saw h alive on 1-28- 1946.

Immediate cause of death	Duration
Cardio-Renal disease	
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....
23. Signature Ph McCargill M. D.
Address 611 N. Canal Date signed 1-30-46

X

636926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

636926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1706 Pierce Street 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): December 23, 1897

8. AGE: Years: 46 | Months: 1 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: House Wife
11. Industry or business

FATHER
12. Name: William Mathews
13. Birthplace: Howard County Md

MOTHER
14. Maiden Name: Alice Butler
15. Birthplace: Howard County Md

16 (a) Informant: Alice Mathews (mother)
(b) Address: 1706 Pierce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 4. 1946 (month) (day) (year)
(c) Cemetery or crematory: Mount Auburn
Location: Baltimore city

18 (a) Funeral director: Joseph A. Pinckney
(b) Address: 409 Mount Street

19 (a) Date received by registrar: JAN 29 1946 (b) Registrar: Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946, at 10:45 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert Lee Preston M.D. (Medical Examiner.)
Date signed 1-29-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G36927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N. Gilmore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Adams

3 (b) If veteran, name war None
3 (c) Social Security Account No. 215-06-4301

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Walter Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, ~~yr.~~) 1-19-~~1~~ 1903

8. AGE: Years 43 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Janitress

11. Industry or business

FATHER
12. Name William Pollard
13. Birthplace Newburn, North Carolina

MOTHER
14. Maiden Name Sarah Barbour
15. Birthplace Newburn, North Carolina

16 (a) Informant Mary Southerland
(b) Address 138 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (Date received by local registrar) (b) Huntington Williams, M.D.

JAN 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946, at 3 P/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1945 to 1-27 1946, and that I last saw h alive on 1-27 1946.

Immediate cause of death Glomerulo-nephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Howell M.D.
Address 600 N. Carrollton Ave Date signed 1/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B2294 — BALTIMORE CITY HEALTH DEPARTMENT — G36968 Registered No.

CERTIFICATE OF DEATH 53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1053 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George King
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lula Mae King
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 16 87
8. AGE: Years 58 | Months 59 | Days 2 | 11 | If less than one day hr. min.
9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Samuel King
13. Birthplace Ga.
MOTHER 14. Maiden Name Priscilla Miller
15. Birthplace Ga.
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 1/30/46 (month) (day) (year)
(c) Cemetery or crematory Lakeland Fla.
Location Lakeland, Florida
18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.
19 (a) (Date rec'd by registrar) (b)
JAN 30 1946 Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1946 at 2 00 M
21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1946 to June 27 1946 and that I last saw him alive on June 27 1946.

Immediate cause of death	Duration
Carcinoma of Kidney, Aglomerular cell type of Kidney	?
Due to	
Due to	
Other Conditions Metastases to kidneys (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy: Ordered

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. M. Williams
Address Johns Hopkins Hosp. Date signed 1-28-46 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

636929 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 E. 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 E 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Green Johnson

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Wdw

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20 1896

8. AGE: Years	Months	Days	If less than one day
52	-	7	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Robert A. Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Cornelia ?
15. Birthplace Maryland

16 (a) Informant Mrs Madge Chambers
(b) Address 437 E 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 31 - 26 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) 30 1926 (Date received by registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-26 19 , at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21-26 19 to 1-27-26 19, and that I last saw her alive on 1-26-26 19

Immediate cause of death Hypertensive Cardio Renal Disease — Duration ?
Due to
Due to
Other Conditions Hemorrhoids Appendectomy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Abrams, MD
Address 312 E 23rd St Date signed 1-30-26

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36930 BALTIMORE CITY HEALTH DEPARTMENT G36930
CERTIFICATE OF DEATH 92 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Bank St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Giza

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Francesnee Stanlee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Store keeper

11. Industry or business Self

FATHER
12. Name John Giza
13. Birthplace Poland

MOTHER
14. Maiden Name Katarzyna Dudek
15. Birthplace Poland

16 (a) Informant Frances Giza
(b) Address 1723 Bank St.

17 (a) Burial (b) Date thereof Jan 31-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. City

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

19 (a) (b)
(Date rec'd by registrar) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1942 to Jan. 28 1946 and that I last saw h alive on Ja. 26 1946

Immediate cause of death	Duration
Acute Cardiac Dilatation	Instant
Due to Chronic Myocarditis & Mitral regurgitation	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Szpudrowicz M. D.
Address 1802 Eastern Ave Date signed 1-29-46

VS 150

G36931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G36931 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 Woodington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Woodington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rachel S. Hargett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1903

8. AGE: Years 42 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name John V. Kilbourne
13. Birthplace Md.

MOTHER 14. Maiden Name Kate Maslin
15. Birthplace Md.

16 (a) Informant Chas. R. Hargett
(b) Address 918 Woodington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1/46. (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

19 (a) (Date received by registrar) JAN 30 1946 (b) Registrar Hastings for Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratz M.D. Medical Examiner.
Date signed 1-29-46

636932

BALTIMORE CITY HEALTH DEPARTMENT 636932

CERTIFICATE OF DEATH 1937

Registered No. 571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Walnut Ave.
(c) Hospital or institution: None.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County NONE.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 WALNUT AVE.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Eugene Travers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE.	MARRIED.

6 (b) Name of husband or wife Ellen B. Travers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 FEB. 1882

8. AGE: Years	Months	Days	If less than one day
63	11	8 23	hr. min.

9. Birthplace TAYLORS ISLAND Md.
(Town, county, and state)
10. Usual Occupation PHYSICIAN.
11. Industry or business

FATHER
12. Name WILLIAM M. TRAVERS
13. Birthplace TAYLORS ISLAND, Md

MOTHER
14. Maiden Name EUGENIA TRAVERS
15. Birthplace CAMBRIDGE, Md.

16 (a) Informant Mrs Ellen Travers.
(b) Address 905 Walnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frank. Road

18 (a) Funeral director Harry H. Nitzke
(b) Address 4104 Eastern Ave

19 (a) (Date rec'd by registrar) JAN 30 1946 (b) Huntington Williamsport Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Jan. 1946, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 JAN 1946, to 28 JAN 1946, and that I last saw him alive on 28 JAN 1946.

Immediate cause of death	Duration 4 hrs
Coronary occlusion, acute	
Due to Chronic Myocarditis	?
Due to Coronary Arteriosclerosis	?
Other Conditions None.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr. M.D.
Address 6312 Mossway Date signed 30 Jan 46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36933 / 123

Registered No. G369.33

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Mt Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose E. Kasemeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Elmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name August Schnappinger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Clara Schorr
15. Birthplace Baltimore

16 (a) Informant Elmer Kasemeyer
(b) Address 506 Mt. Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Henry A Wetzel
(b) Address 4101 Edmondson ave

19 (a) (Date rec'd by registrar) JAN 30 1946 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1946 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1945 to 1/29 1946 and that I last saw her alive on 1/27 1946

Immediate cause of death	Duration
Myocardial failure	
Due to Generalized Peritonitis	
Due to Ruptured Diverticuli of Sigmoid	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. H. D'Elia Jr M. D.
Address St Agnes Hosp Date signed 1/29/46

G36934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G36934 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Brown (Jesse A. Brown Jr.)
3 (b) If veteran, name war None
3 (c) Social Security Account No. 218-03-8923

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Eva
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) February 14 1888
8. AGE: Years 57 Months 11 Days 15 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name William Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Marie Lee
15. Birthplace Md.

16 (a) Informant Jesse A. Brown Jr.
(b) Address 637 N. Hooker St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Joseph L. Young
(b) Address 804 N. Carlisle St.
19 (a) JAN 30 1946 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946, at 1:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1946, to Jan 29 1946, and that I last saw him alive on Jan 29 1946.

Immediate cause of death	Duration
Respiratory obstruction	
Due to Ca of Esophagus	
Due to	
Other Conditions Mediastinitis Malnutrition	

(Include pregnancy within 3 months of death)
Date of operation Jan 29, 46
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Osmund Akinson M. D.
Address Univ. Hospital Date signed 1/29/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Tunbridge Rd
(c) Hospital or institution: * * *
(d) Length of stay in hospital or inst. (yrs., mos., or days) * W-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Tunbridge Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country * * *

3 (a) FULL NAME Charles H. Fear Jr

3 (b) If veteran, name war * *

3 (c) Social Security Account No. * * *

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife * * *

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) Apr 4 - 1928

8. AGE: Years 17 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation * *

11. Industry or business * *

FATHER
12. Name Charles H. Fear
13. Birthplace Penna

MOTHER
14. Maiden Name Mary E. White
15. Birthplace Baltimore

16 (a) Informant Charles H. Fear Sr.
(b) Address 624 Tunbridge Rd.

17 (a) Burial (Burial, [redacted]) (b) Date thereof Jan 31-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 418 W Mt Royal Ave

19 (a) JAN 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1946 to Jan 29 1946, and that I last saw him alive on Jan 29 1946

Immediate cause of death: Acute heart failure — Duration: 4 hours

Due to: Has been an invalid confined to his bed all his life -

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation No operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Gibson Porter

Address 4622 Roland Ave Date signed 1/30/46

over

VS 150

G36936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. G36936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Parkville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vera Elizabeth Hyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Irwin Hyman
6 (c) If alive, give age 1898 ~~1899~~

7. Birth date of deceased (mo., day, yr.) May -

8. AGE: Years	Months	Days	If less than one day
~~47~~	10	18	hr. min.

9. Birthplace Indianapolis Indiana (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER 12. Name Wm. O. Wolf
13. Birthplace

MOTHER 14. Maiden Name Ida C.
15. Birthplace -

16 (a) Informant Mrs. Irving Hyman
(b) Address 3913 Parkville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-46 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Balto.

18 (a) Funeral director Leonard J. Lusk
(b) Address 5305 Hanford Rd

19 JAN 30 1946 (Date rec'd by reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1946 to Jan 29 1946 and that I last saw her alive on Jan 29 1946.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Pneumococcus meningitis & Acute bacterial endocarditis	
Due to 3. Uremia	
4. Renal failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome A. Hirschman M. D.
Address Sinai Hospital Date signed 1/29/46

VS 150

(over) Jerome Hirschmann

G36937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G36937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 N. Kenwood Avenue
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE MATCZUK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Felix
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1896

8. AGE: Years	Months	Days	If less than one day
49	5	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Household
11. Industry or business

FATHER
12. Name John Borkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Eva Prudzinska
15. Birthplace Poland

16 (a) Informant Mrs. Siwak
(b) Address 2531 Asquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Ave

19 (a) JAN 30 1946 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946 at 9.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1946 to Jan 28 1946 and that I last saw her alive on Jan. 28 1946.

Immediate cause of death Cerebral hemorrhage — Duration 1/28/46

Due to Arterio - sclerotic cardio - vascular disease with hypertension — years

~~Due to~~

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M. D.
Address 406 S. Patterson Pk. Ave. Date signed 1/29/46

636938 Geneva # 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

636938 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals 76

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Remate, infirmary
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 City Hospitals
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

3 (a) FULL NAME William Bramley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) April 17, 1859

8. AGE: Years	Months	Days	If less than one day
86 87	9	6	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Bramley
13. Birthplace England

MOTHER
14. Maiden Name Margaret Hughes
15. Birthplace England

16 (a) Informant Himself.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JAN 30 1946

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 30 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-1946 at 12 Noon M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Generalized Arteriosclerosis

Due to

Other Conditions Postmortem changes of tissues & organs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-23-46

VS 151

G369.59 — Larone #3 — G369.59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 183

Registered No.

1. PLACE OF DEATH Formerly Harbor Post #3 U.S. Coast Guard
(a) Baltimore City, Maryland
(b) Street address 700 E. Lee Street
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown - White male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 50? Months: Days: If less than one day ..... hr. ..... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JAN 30 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 30 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-1946 at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Body recovered 1-13-46 at 9:45 A.M.
(b) Where did injury occur? From Harbor - Foot of E. Lee St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 1-14-46

VS 151

...item of information should be carefully supplied. The ...UNFADING INK. Every ... correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

G36940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G36940
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 S. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Gottschalk

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1875

8. AGE: Years 70 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Francis X Gottschalk
13. Birthplace Germany

MOTHER
14. Maiden Name Katharine A. Kreiglstein
15. Birthplace Germany

16 (a) Informant Francis X Gottschalk
(b) Address 419 S Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director N. W. E. Dugan Sons
(b) Address Homewood Ave & 39th St

19 (a) Date registered JAN 30 1946 (b) Registrar Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1946 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28- 1945 to 1-28 1946, and that I last saw him alive on 1-28 1946.

Immediate cause of death: Myocardosis — Duration

Due to: Hypertensive Heart Disease

Due to: Essential hypertension

Other Conditions: Arteriosclerosis. Cerebral accident.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J J Gould MD
M. D.
Address 142 E 25th St Date signed 1-29-46

G3693:1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G3693:1

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2119 Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2119 Park Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** ALBERT SALOMON

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife EVA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name NOT KNOWN

13. Birthplace GERMANY

MOTHER 14. Maiden Name NOT KNOWN

15. Birthplace GERMANY

16 (a) Informant JESSIE S. FINEMAN

(b) Address 2119 PARK AVE

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 1-31-46 (month) (day) (year)

(c) Cemetery or crematory NEW YORK CITY

Location

18 (a) Funeral director JACK LEWIS INC

(b) Address 1439 E. BALTO. ST.

19 (a) JAN 31 1946 (b) Huntington Williams M.D.

Registrar by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30/1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to 1/30 1946 and that I last saw him alive on 1/30 1946.

Immediate cause of death	Duration
Cardio-Renal	4 yrs
Due to Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Benj. Samuels M.D.

Address 2128 W. North Ave Date signed 1/31/46

VS 150

G36942 — BALTIMORE CITY HEALTH DEPARTMENT — G36942 Registered No.

CERTIFICATE OF DEATH 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tiaconny Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Raynegr RAYNER Classen

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr. Henry Washington Classen
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1885

8. AGE: Years	Months	Days	If less than one day
60	11	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Harry S. Rayner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Johnetta Ward Bartholow
15. Birthplace Baltimore, Md.

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (F. F. Mowen Sons.) 100 W. North Avenue

JAN 30 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1946, at 8 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1946 to Jan. 30 1946, and that I last saw h e alive on Jan. 30 1946.

Immediate cause of death	Duration
Myocardial infarction	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leyle J. Arnold M. D.
Address U. M. H. Date signed 1-30-46

G36943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G36943

RELEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 N. Lanvale St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Emily Chatard Dugan

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: (none)
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 22 1859

8. AGE: Years 88 | Months 7 | Days 7 | If less than one day — hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Cumberland Dugan
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Harriet Buchanan
15. Birthplace Maryland

16 (a) Informant Mr C. Nelson Dugan
(b) Address 131 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Sherlock Mortuary Co
(b) Address 108 W Madison

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946, to Jan 30 1946, and that I last saw h.. alive on Jan 29 1946.

Immediate cause of death: Cerebral Arterio Sclerosis — Duration: 1 yr
Myocardial Insufficiency — 1 month
Due to Arterio Sclerosis — many years
Due to —
Other Conditions
(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Collins M. D.
Address 1004 Calvert St Date signed Jan 31 46

VS 150

Huntington Hillsboro Md

X

G36944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered No. G36944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 S Light St.
(c) Hospital or institution: Balto. Public Wel. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter O. Snyder Sr.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Lillian Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22nd 1866

8. AGE: Years 79 | Months 7 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business State Farm Bur. Co.

FATHER
12. Name William W. Snyder
13. Birthplace Md.

MOTHER
14. Maiden Name Rosella J Taggart
15. Birthplace Md.

16 (a) Informant Harold L. Harvey
(b) Address 2935 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1st 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JAN 31 1946 (Date received by Local Registrar) (b) Huntingtown for Williams MD (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-46 19..... at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1946, to 1-29 1946, and that I last saw him alive on 1-29-46 19.....

Immediate cause of death	Duration
Carcinoma of Kidney	4 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....

23. Signature Harold L Harvey M.D.
Address S.B.C.H. Date signed 1-29-46

G36945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G36945

TM. 98499

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1050 N. Gay St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dangerfield Ruth (Baby Boy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12th 1946

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Dangerfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth Taylor
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) JAN 31 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14th. 1946 at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12th 1946 to Jan. 14 1946 and that I last saw him alive on Jan. 14 1946

Immediate cause of death	Duration
Atelectasis	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Not done

Major findings of operation:

of autopsy: Not attended

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address Date signed 1/31/46

VS 150

G36946

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G36946

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 V Ellamont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D C (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1368 G' Stud S.E (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Sears

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NNG

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct 6 1880
8. AGE: Years 65 Months 3 Days 24 If less than one day hr. min.
9. Birthplace: Washington DC (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Samuel S Strong
13. Birthplace: New York

MOTHER
14. Maiden Name: Libbie Marridge
15. Birthplace: Maryland

16 (a) Informant: Samuel Sears
(b) Address: 1368 G St NE Wash DC
17 (a) Samuel (Burial, cremation, or removal) (b) Date thereof 1/31/46 (month) (day) (year)
(c) Cemetery or crematory: Washington
Location: Washington DC
18 (a) Funeral director: Wells Chamber Co
(b) Address: Wash DC

JAN 31 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1946, at 10 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to Jan 30 1946, and that I last saw h. alive on Jan 30 1946

Immediate cause of death	Duration
Mitral Insufficiency	
Mitral Stenosis	
Due to Hypertension	
Chronic Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —
23. Signature: Milton Siocumb M. D.
Address: 24 Ellamont St Date signed Jan 30 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

G36947
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2134 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate A. Firor

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Grason J. Firor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1870

8. AGE: Years	Months	Days	If less than one day
75	1	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John R. Van Sant
13. Birthplace Holland

MOTHER
14. Maiden Name Johanna Maher
15. Birthplace County Cork, Ireland

16 (a) Informant Mrs. Charles Phelps
(b) Address 2134 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 31 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Jan 29 1946 and that I last saw h[illegible] alive on Jan 29 1946.

Immediate cause of death	Duration
Bronchial asthma	6 wks.
Due to	
Due to	
Other Conditions Hypertension	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad Gordon M. D.
Address 2201 W. North Ave Date signed 1-28-46

Huntington Williams, Registrar

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36948
487499.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G36948

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME R. Victoria Ford.

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-16-44.

8. AGE: Years 1 | Months 5 | Days 14 16 | If less than one day ..... hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Edward Ford. Emerson
13. Birthplace Md. (Talbot Co.,)

MOTHER
14. Maiden Name Ruth Fruzell
15. Birthplace Roanoke Md.

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1/31/45 (Date rec'd by registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 30 1946, at 5.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1946, to Jan. 30 1946, and that I last saw her alive on Jan. 30 1946.

Immediate cause of death: Salicylate poisoning — Duration: 36 hours
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/5
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1-28-46 at P. M
(c) Where did injury occur? 2207 E. Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury swallowed 20 tablets

23. Signature Clifton W. Gordon Jr. M.D.
Address 1 E Hoffman Date signed 1-30-46

Huntington Williams, M.D.
Bernhart Steinberg M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 5369 49

5369 49 720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Winchester Ave #16 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amy Gertrude Drafts

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Carl L. Drafts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 30, 1891

8. AGE: Years	Months	Days	If less than one day
54	6	29	hr. min.

9. Birthplace: Marion Station, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Ira N. Coulbourn
13. Birthplace: Marion Station, Md.

MOTHER
14. Maiden Name: Florence Tull Coulbourn
15. Birthplace: Kingston, Md.

16 (a) Informant: Miss Florence M. Draft
(b) Address: 2911 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Pk.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

JAN 31 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29th 1946, at 5.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22nd 1946, to Jan 29th 1946, and that I last saw her alive on Jan 29th 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerosis	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez
Address Maryland General Hospital Date signed 1/30/46 M.D.

GONZALEZ

636950 2 BALTIMORE CITY HEALTH DEPARTMENT 636950
CERTIFICATE OF DEATH 94a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 So. Paca St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Catherine A Childs
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 15, 1894

8. AGE: Years	Months	Days	If less than one day
51	3	15	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation HW
11. Industry or business Home

FATHER
12. Name Henry Snyder
13. Birthplace Md

MOTHER
14. Maiden Name Mary Wheeler
15. Birthplace Md

16 (a) Informant Lula E. Taylor
(b) Address 805 Hollins St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave
18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St
19 (a) (Date rec'd by registrar) (b) Registrar
JAN 31 1946 Huntington Williams, MD

MEDICAL CERTIFICATION
20. DATE OF DEATH 1/30 1946 at 8:40 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 1946 to 1/30 1946, and that I last saw h[illegible] alive on 1/29 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Hypertension Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel Cook M. D.
Address Univ. Hosp. Date signed 1/30/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36951 (1) BALTIMORE CITY HEALTH DEPARTMENT 937 G36951

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1939 Herbert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 Herbert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Monroe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Harry E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 12, 1872

8. AGE: Years	Months	Days	If less than one day
73	11	17	hr. min.

9. Birthplace Washington. N. C (Town, county, and state)
10. Usual Occupation Lodge wife
11. Industry or business at home

FATHER
12. Name John Smith
13. Birthplace North Carolina

MOTHER
14. Maiden Name Oxendine
15. Birthplace North Carolina

16 (a) Informant Mrs Harry E Monroe
(b) Address 1939 Herbert St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 2/2/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John Goodwin Son
(b) Address 901-03 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 31 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 45 to Jan 29 1946, and that I last saw h alive on Jan 19 46.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1314 St. Paul St Date signed 1/30/46

VS 150

P 35344 ✓

G36932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G369[illegible] No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution: West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 W Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James McHenry Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 October 45

8. AGE: Years	Months	Days	If less than one day: hr.	min.
	3	23		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James A. McHenry
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Grace E. Stencil
15. Birthplace Baltimore, Md

16. (a) Informant Mrs. Grace Stencil
(b) Address 1028 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)
(c) Cemetery or crematory London Gardens
Location 3801 Hedgerow Ave

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-3 Fidelity St

19 (a) (Date rec'd by registrar) JAN 31 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1946 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 January 1946 to 30 Jan 1946 and that I last saw h[illegible] alive on 30 Jan 1946.

Immediate cause of death Respiratory Failure — Duration
Due to Pneumonia
Due to
Other Conditions Sclerosis Congenital Palsy - Intracranial Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester G. Stencil Jr.
Address H. B. Gen. Hosp. Date signed 1/30/46 M. D.

VS 150

G36953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 365453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Milford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Milford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cowan Noel

3 (b) If veteran, name war	3 (c) Social Security Account No. 214-01-6106

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife A. Loretta Noel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1892

8. AGE: Years	Months	Days	If less than one day
53	1	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Cannon Shoe Co

FATHER
12. Name Charles A. Noel
13. Birthplace France

MOTHER
14. Maiden Name Anna Kirchner
15. Birthplace Germany

16 (a) Informant A. Loretta Noel
(b) Address 3108 Milford Ave

17 (a) Burial (b) Date thereof Feb 1 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn MD

18 (a) Funeral director Harry J. Armacost
(b) Address 4204 Ridgewood Ave

19 (a) JAN 31 1946 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31st 1946, at 12:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to Jan. 30 1946 and that I last saw him alive on Jan. 30 1946.

Immediate cause of death
1) Cerebral Hemmorrhage — Duration -12 hrs.
Due to Hypertension
Heart Disease — 3 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 1/31/46

EARL L. CHAMBERS

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636954 ✓ 636954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Monument (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. William Dunan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna Dunan

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Machinist

FATHER
12. Name Frederick Dunan
13. Birthplace Germany

MOTHER
14. Maiden Name Doris Wolle
15. Birthplace Germany

16 (a) Informant Anna Dunan
(b) Address 3103 E Monument

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/1/1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) 2-1-1946 (Registered by registrar) Ketring for Williams, M.D. Registrar

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/1946 at 5:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13/1946 to 1/29/1946 and that I last saw him alive on 1/29/1946

Immediate cause of death: Carcinoma Head of Pancreas. — Duration 6 mo.

Due to

Due to

Other Conditions Cachexia

(Include pregnancy within 3 months of death)

Date of operation Nov. 1945

Major findings of operation: Obstruction Pyloric End of Stomach - Gastroenterostomy

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged primarily.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Norton Jr. M.D.

Address 806 Seven Mary. Date signed 1/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G36955

G36955

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MATHILDA FLYNN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 7, 1872

8. AGE: Years	Months	Days	If less than one day
73	7	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home.

FATHER
12. Name Thomas Clark
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Norton
15. Birthplace Ireland

16 (a) Informant Dr. Philip J. Flynn
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-46 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location City

18 (a) Funeral director Mary M. Smith
(b) Address 50 E. 22nd St. Baltimore, Md.

19 (a) 2-1-1946 (Date rec'd by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 19 46 at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 19 46 to 1/30 19 46 and that I last saw her alive on 1/30 19 46.

Immediate cause of death Cerebral hemorrhage. — Duration 4 days

Due to

Due to

Other Conditions Auricular fibrillation.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Hedrick M. D.
Address Mercy Hospital Date signed 1/30/46

636956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

636956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5709 Roland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5709 Roland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Herbert Boehm

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-18-7243

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Catherine M Kimble

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1862

8. AGE: Years 83 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Banking

11. Industry or business

FATHER
12. Name Charles T. Boehm
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine Sauerwein
15. Birthplace Baltimore Md.

16 (a) Informant Margaret D. Boehm
(b) Address 5709 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 1946 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location St. Thomas Church Garrison Forest

18 (a) Funeral director Henry W Jenkins Sons Co
(b) Address McCulloh & Orchard sts

19 (a) (b)
(Date rec'd by registrar) Hampton Williams, Registrar

VS 150 JAN 31 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11, 1946 to Jan 28 1946, and that I last saw him alive on Jan 28 1946.

	Duration
Immediate cause of death: chronic myocarditis	several years.
Due to: arteriosclerosis	10 years
Due to:	
Other Conditions: none	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank R. Smith, Jr. M. D.
Address 1014 St Paul St. Date signed 1/30/46.

G36957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87E

Registered No. G36957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angeline Cicchetti

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1930

8. AGE: Years 15 | Months 7 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Angelo Cicchetti
13. Birthplace Italy

MOTHER
14. Maiden Name Virginia Trombetta
15. Birthplace Baltimore Md.

16 (a) Informant Virginia Cicchetti (Mother)
(b) Address 907 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1st 1946 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Paul Della Rocca
(b) Address 52 N. Morley St.

JAN 31 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to Jan 29 1946, and that I last saw her alive on Jan. 28 1946

Immediate cause of death	Duration
Pulmonary Oedema	1 day
Due to Acute Cardiac Dilatation	
Due to Congenital Spastic Paraplegia	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2260 E. Madison Date signed 1/31/46

VS 150

G36958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G36958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 Dennlyn Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Dennlyn Rd (If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isaac Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (City, county, and State)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Hosea A. Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name ~~Hooker Lewis~~ Hooker
15. Birthplace Russia

16 (a) Informant Rose Cohen
(b) Address 3701 Dennlyn Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1609 E Balto St

19 (a) ... (b) Huntington Williamsport, Md
(Signature or address of person acting for undertaker)

JAN 31 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1946 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 30 1946 and that I last saw h... alive on Jan 30 1946.

Immediate cause of death Myocarditis arteriosclerosis
Acute cardiac dilatation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Kahn M. D.
Address 2306 Eutaw Pl Date signed 1-30-46

X

G36959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G36959

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 St. George Ave.
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos. or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 St. George Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Francis Leatt

3 (b) If veteran, name war	3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1932

8. AGE: Years	Months	Days	If less than one day
13	10	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Daniel Leatt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Daisy Johnson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Daisy Stevens
(b) Address 4403 St. George Ave.

17 (a) Burial (b) Date thereof Feb. 1, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lou. H. Stella
(b) Address 1601 Druid Hill Ave
(Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1946; at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5, 1945 to Jan 27, 1946 and that I last saw him alive on Jan 26, 1946

Immediate cause of death	Duration
Broncho-Pneumonia	3 wks.
Due to	
Due to	
Other Conditions Partial Paralysis of muscles of Pharynx (Include pregnancy within 3 months of death)	8 mos.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.
Address 2445 Druid Hill Ave. Date signed 1-29-46

VS 150

G36960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. G36960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER STS
(c) Hospital or institution: ST JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO CITY
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELIJH Mc INTYRE
3 (b) If veteran, name war
3 (c) Social Security Account No. 241-28-5985

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband Chas M. McIntyre
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) April 2-1889

8. AGE: Years	Months	Days	If less than one day
56	-9	-28	hr. min.

9. Birthplace Hollow Rock Tenn.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name M. Buttler
13. Birthplace Tenn

MOTHER
14. Maiden Name Mrs Parks
15. Birthplace Tenn.

16 (a) Informant Mrs Sarah Thomas
(b) Address 1327 Patapsco Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Memorial Park
Location Baltimore Md

18 (a) Funeral director Milton S. Killing
(b) Address 3914 E Hanover St

JAN 31 1946 (Date received by local registrar) (b) Huntington Millington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 30 1946, at 2.06 M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 23 1946 to JAN 30 1946 and that I last saw her alive on JAN 30 1946

Immediate cause of death UREMIA — Duration

Due to BRIGHT'S DISEASE

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Weis M. D.
Address ST JOS. HOSP Date signed 1-30-46

VS 150

G36961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G36961

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1640 N. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1640 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband ~~or wife~~ Herman Johnson Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-1900

8. AGE: Years	Months	Days	If less than one day
45 yrs	5	4 5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Clayton
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland

16 (a) Informant Patient (deceased)
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore City

18 (a) Funeral director Geo. R. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 31 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945 to 1-31 1946, and that I last saw her alive on 1-30 1946

Immediate cause of death Uremia — Duration

Due to Carcinoma cervix — League of Nations TB

Due to

Other Conditions Abscess abdominal wall

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan

Address 609 E Broadway Date signed 1-31-46

X

G36962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G36962

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife John R. Garrett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Boston
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alma Gilles
15. Birthplace Balto. Md.

16 (a) Informant Jesse Valentine
(b) Address 1019 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Gilliard
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) JAN 31 1946 (b) Registrar Thos. Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 46, at 4:41 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 46 to 1/24 46 and that I last saw him alive on 1/24 1946.

Immediate cause of death	Duration
Cerebral Apoplexy	
Due to Paralysis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Date signed 1/26/46

AB- 636963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

636963 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 252 N. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13- 1900

8. AGE: Years	Months	Days	If less than one day
45	8	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name James Taylor
13. Birthplace Md.

MOTHER 14. Maiden Name Susan ?
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 229 N. Schroeder St.

19 (a) JAN 31 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1946 at 11:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28-46 1946 to 1-28- 1946 and that I last saw him alive on 1-28- 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 1-30-46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46.33407 — 131a — Registered No. 6369d4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	married

6 (b) Name of husband or wife Arnetta
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) ? ?1904

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Charles Cole
13. Birthplace va.

MOTHER
14. Maiden Name Attis Ree.
15. Birthplace va

16 (a) Informant Reeves
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Lehmoedes St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 31 1946

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 29 1946 at 3.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1946 to Jan. 29 1946 and that I last saw him alive on Jan. 29 1946.

Immediate cause of death Uremia — Duration ?

Due to Chronic Glomerulonephritis and Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Williams M. D.
Address John Hopkins Hospital Date signed 1-29-46

X

G36965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G36965 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 850 Maryfold
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 Maryfold St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Cook

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1866

8. AGE: Years	Months	Days	If less than one day
79	3	1	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baltimore Transit

FATHER
12. Name Archie Cook.
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Jordan
15. Birthplace Ireland

16 (a) Informant Mrs Mary E. Cook
(b) Address 850 Maryfold St.

17 (a) burial (b) Date thereof 2/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Hedgerow Ave

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 St Paul St

19 (a) (Signature of [illegible]) (b) Hamilton for Williams, M.D. Registrar

JAN 31 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1946 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 to — 19 and that I last saw h[illegible] alive on — 19

Immediate cause of death Uraemia Nephrosclerosis — Duration 2 yrs.
Due to Hypertensive Cardio-Vascular Renal disease
Due to senile arteriosclerosis generalized.
Other Conditions Ecchymosis right eye.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John O. Ulrich Jr
Address (122) Wade Ave Date signed 31 Jan '46

G36966 anchorage Hotel Brohdyay G36966 St
X 108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Born
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Chesson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Daniel Rowls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 40 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Veterans Administration
(b) Address 1315 A. Penn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Parkside Penn

18 (a) Funeral director Odell Funeral Home Inc.
(b) Address 4644 Old Frd

19 JAN 31 1946 (b)
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION 45

20. DATE OF DEATH January 16, 1946 at 9 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 1
Lobar pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed Jan 17, 1946.

G369667

BALTIMORE CITY HEALTH DEPARTMENT

HB #85488 CERTIFICATE OF DEATH ✓108

G369667 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1 10
(e) Length of stay in Baltimore (yrs., mos., or days) 77 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 N. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Drake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	27	hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bird Drake(d)
13. Birthplace Ga.

MOTHER 14. Maiden Name Jane Sheppard
15. Birthplace Ga.

16 (a) Informant Balto. City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2-1-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co. Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) Jan 31 1946 (b) Received Jan 31 1946 Registrar Wilmington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1946, at 5:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18, 1945 to Jan. 28, 1946 and that I last saw h. alive on Jan. 28, 1946

Immediate cause of death: cerebrovascular accident — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions: Lobar pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address 6 E. Mt. Date signed 1/29/46

VS 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 636968

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name James H. Wilson

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Estelle T. Thomas (Daughter)

(b) Address 414 N. Carey St.

17 (a) Burial (b) Date thereof Feb. 2 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem.

Location Arbutus Md.

18 (a) Funeral director Dolan Bailey

(b) Address 1421 E. Jefferson St.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 31 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.

Date signed 1-29-46

636969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

636969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Ayrdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth S. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife James S. Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1885

8. AGE: Years	Months	Days	If less than one day
60	11	8	hr. min.

9. Birthplace Franklin Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Snyder
13. Birthplace Rockland Township, Pa.

MOTHER
14. Maiden Name Susan Fulmer
15. Birthplace Pa.

16 (a) Informant Mrs. Raymond Ferguson
(b) Address 3904 Ayrdale Ave.

17 (a) Burial-Removal (b) Date thereof Feb. 2, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Franklin Pa.
Location

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (b)
(Date received by Local Registrar) Huntington Williams, M.D.
JAN 31 1946

VS 150

MEDICAL CERTIFICATION.

20. DATE OF DEATH 1/31 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1946 to 1/31 1946, and that I last saw her alive on 1/30 1946.

Immediate cause of death	Duration
Coronary Thrombosis	7 days
Due to Arteriosclerotic C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 1/31/46

THE MOHLAX G36970

BALTIMORE CITY HEALTH DEPARTMENT

G36970 **CERTIFICATE OF DEATH** 181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 So Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 2
(e) Length of stay in Baltimore (yrs., mos., or days) 8 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Padonaca St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John. T. Formollan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 | 19 | 37

8. AGE: Years 8 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Pupil

11. Industry or business

FATHER
12. Name Robert Formollan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Maizie Hollinshead
15. Birthplace Baltimore

16 (a) Informant Robert Formollan
(b) Address 1803 Padonaca St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 1-1-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. E. McCurdy
(b) Address 1600 E. Fayette Ave

19 (a) JAN 31 1946 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946, at 2:03 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan 29 1946, and that I last saw deceased alive on Jan 29 1946.

Immediate cause of death	Duration
Late effects of 2nd + 3rd Degree	
Due to burns of the legs buttocks	
Due to genitalia + abdomen	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 23/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1/5/46 at 11:15 A.M.
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Burning bonfire.

23. Signature J. Murdock M.D.
Address S. Balto Gen Hosp Date signed 1/29/46 M. D.

VS 150 S. C. J. Lubowski, by Howard J. Morris, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636971 — BALTIMORE CITY HEALTH DEPARTMENT — 636971

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4618 Kavon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Kavon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Lewis Huff

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife May Elizabeth Huff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26th, 1863

8. AGE: Years	Months	Days	If less than one day
82	7 8	5	hr. min.

9. Birthplace Town Creek, Maryland (Town, county, and state)
10. Usual Occupation Leather tanner
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Nita Belle Wise
(b) Address 4818 Kavon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-46 (month) (day) (year)
(c) Cemetery or crematory Hill Crest Cemetery
Location Cumberland, Maryland
18 (a) Funeral director Frederick D. Miller, Inc
(b) Address 3019 E. Monument Street

JAN 31 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945, to Jan 31 1946 and that I last saw h alive on Jan 30 1946

Immediate cause of death Ch. Myocarditis — Duration 10 years
Due to Arteriosclerosis
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Hardesty M. D.
Address 4818 Kelair Rd Date signed Jan 31/46

G36972

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 108

Registered No. G36972

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles Francis Pittinger ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-0145

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Mrs. Chas. F. Pittinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1883

8. AGE: Years 62 | Months 5 4 | Days 8 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Optician mechanic

11. Industry or business

FATHER 12. Name Verbal Pittinger

13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Garrett

15. Birthplace Baltimore

16 (a) Informant hospital records

(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2/2/46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

FEB 1 1946 Lettington Williams, M.D. Registrar
(Date rec'd by local reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1946, at 7 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1946, to Jan. 30 1946, and that I last saw him alive on Jan. 30 1946.

Immediate cause of death	Duration
pulmonary embolism	
Due to arteriosclerotic heart disease & decompensation	
Due to lobar pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy pulmonary embolism; lobar pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kirkpatrick, Jr. M.D.

Address Union Memorial Hosp. Date signed 1-30-46

VS 150

X

G36973

Medical Examiner.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G36973

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 E. Fayette St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Jean Nash.

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-14-93

8. AGE: Years	Months	Days	If less than one day
52	2	16	..... hr. ..... min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Joseph B. Sharar
13. Birthplace md.

MOTHER
14. Maiden Name Rozabelle Wetmer
15. Birthplace md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (c) Date received by registrar FEB 1 1946 Registrar Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30th 1946. at 5 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1946. to Jan. 30 1946. and that I last saw her alive on Jan. 30 1946.

Immediate cause of death	Duration
Circulatory Collapse	1 hr
Due to Extensive Third Degree Burns	11 days
Due to Pulmonary Emboli	1 day
Other Conditions Extensive 2nd & 3rd Burn (Include pregnancy within 3 months of death)	11 days

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 6/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1/19/46 at 3 A M
(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury. Smoking cigarette in bed
23. Signature J. E. Conrad M.D.
Address Johns Hopkins Hosp. Date signed 1/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

For B.J.R. Davis by Howard J. Morrison, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

63974 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 W. Lexington Street

(c) Hospital or institution:

Aged Woman's & Aged Men's Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1400 W. Lexington St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME LEONARD CURTIS TREHERNE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1855

8. AGE: Years	Months	Days	If less than one day
90	8	12	hr. min.

9. Birthplace Northampton Co. Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Curtis Treherne

13. Birthplace

MOTHER

14. Maiden Name Harriett Anne Johnson

15. Birthplace

16 (a) Informant Aged Women's & Aged Men's Home

(b) Address 1400 W. Lexington Street

17 (a) Burial (b) Date thereof 2/2/46

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) FEB 1 1946 Huntington Williams M.D.

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1946, at 6.05A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18/45 19 to 1/31/46 19, and that I last saw him alive on 1/29/46 19

Immediate cause of death	Duration
Coronary insufficiency	1 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward B. Jarrett M. D.

Address 11 E. Chase St., City Date signed 1/31/46

VS 150

G36973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

Registered No. G369?5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Md. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Harford

(c) City or town Edgewood
(If outside city or town limits, write RURAL and give town)

(d) Street No. 22 Dexter st.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Lee Dykstra

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 14, 1944

8. AGE: Years 1 | Months 6 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dewey Dykstra
13. Birthplace Texas

MOTHER
14. Maiden Name Catherine Dawson
15. Birthplace Virginia

16 (a) Informant Wm. Cook Inc.

(b) Address

17 (a) Burial (b) Date thereof 2/2/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Maryland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

FEB 1 1946 (b) [illegible] Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30th 1946, at ... M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Asphyxia

Due to during administration of Anesthesia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-30-46 2 P.M.

(b) Where did injury occur? Hospital

(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? no

(d) Means of injury

23. Signature Benedict Skutarelis M.D.
Medical Examiner.

Date signed 2-1-46

VS 151

G36976 ✓ G36976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Ridgely st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George D Oetken

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-4636

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or wife~~ Marie Oetken

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31st 1866

8. AGE: Years	Months	Days	If less than one day
79	1	0	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Potthast Bros

FATHER 12. Name Unknown Oetken

FATHER 13. Birthplace "

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace

16 (a) Informant Mrs. Marie Winkler

(b) Address 2049 Hollins st.

17 (a) Burial (b) Date thereof 2/2/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Trinity
Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st

19 (a) FEB 1 1946 (b) Name of Registrar

Date rec'd by Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1946 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1946 to 1/31 1946 and that I last saw him alive on 1/31 1946

Immediate cause of death	Duration
myocardial degeneration	
& heart failure	
Due to arteriosclerosis	
Due to	
Other Conditions possible chronic glomerulonephritis (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Daengler M.D.
Address University Hosp Date signed 1/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS 150

G36977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G36977 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)
(d) Street No. Railroad Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adam Steyer
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-0292

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Katherine E. Steyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1913

8. AGE: Years 32 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Painting
11. Industry or business Chevrolet Co.

FATHER
12. Name Peter Steyer
13. Birthplace Austria

MOTHER
14. Maiden Name Barbara Krebs
15. Birthplace Austria

16 (a) Informant Mrs. Adam Steyer
(b) Address Railroad Ave., Glenburnie

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto., Md.

18 (a) Funeral director Loeacker Funeral Home
(b) Address 7401 Belair Road

FEB 1 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1946 at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1946 to 1/30 1946 and that I last saw him alive on 1/30 1946

Immediate cause of death	Duration
resp paralysis	
Due to Post Cranial Brain tumor - Glioma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1/29/46
Major findings of operation: Glioma in left frontal lobe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James R McCormack Jr M.D.
Address Westminster, Md. Date signed 1/30/46

VS 150

G369.8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

184

Registered No. G369.8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4900 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William C. Weber

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elizabeth Weber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1875

8. AGE: Years 70 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore County Md
(Town, county, and state)

10. Usual Occupation Dairy farmer

11. Industry or business Farming

FATHER
12. Name Jacob Weber
13. Birthplace Germany

MOTHER
14. Maiden Name ----- Schultz
15. Birthplace Germany

16 (a) Informant Mrs Wm. C Weber
(b) Address 4900 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

FEB 1 1946 Hattie Lee Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946 at 6.30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shot Gun shot wound of head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 31 1946 M.
(b) Where did injury occur? 4900 Sinclair Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot gun wound of Head

23. Signature Benedict Ostarello M.D.
Medical Examiner.
Date signed 1-31-46

140

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HB #98656

G36979 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Howard Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mina Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1890

8. AGE: Years: 55 | Months: 10 | Days: 14 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joshua Harris
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachell Harris
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Anne Arundel Co. Md

18 (a) Funeral director Williams J. Chatman Jr
(b) Address 1201 McCulloh St city.

FEB 1 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1946, 5:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18, 1946 to Jan. 28, 1946 and that I last saw h im alive on Jan. 28, 1946

Immediate cause of death	Duration
H C V D	7
Due to	
Due to	
Other Conditions Renal insuff.	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Mc Davis M. D.
Address B. C. H. Date signed 1/31/46

VS 150

G36980 G. Hoo77

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59

Registered No. 351078 G36980

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Calvert
(c) City or town Barstow
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1946

8. AGE: Years | Months | Days | If less than one day: 2 hr. 05 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Frank Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth Green
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School JAN 31 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 1 1946 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946, at 5:00 P/M

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 1946, to January 19 1946, and that I last saw him alive on January 19 1946.

Immediate cause of death	Duration
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hospital Date signed

3270 X

G36981 G-40650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G36981 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 156 - Route 16 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Female Infant Moyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-46

8. AGE: Years | Months | Days | If less than one day: hr. 10 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Vernon Moyer
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Antoinette Cesmotorsky
15. Birthplace Baltimore

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 31 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 1 1946 (Date rec'd by Registrar) Walter [illegible] (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-46 19 , at 10 23/ M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29- 1946 to 1-29 1946 and that I last saw h alive on 1-29 1946

Immediate cause of death: Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Yglas M. D.
Address 876 Wolfe St Date signed

VS 150

0 3271

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36936 — BALTIMORE CITY HEALTH DEPARTMENT — G36936 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Loyola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days) 56yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Yetta Levitas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: Houe Work

FATHER
12. Name: Hyman Scherr
13. Birthplace: Russia

MOTHER
14. Maiden Name: Freda ?
15. Birthplace: Russia

16 (a) Informant: Sol Levitas
(b) Address: 2601 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1. 1946 (month) (day) (year)
(c) Cemetery or crematory: Bnai Israel Cemetery
Location: Southern Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) Date received by registrar: FEB 1 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1945 to Jan. 31, 1946 and that I last saw h. alive on Jan. 31, 1946.

Immediate cause of death: Myocardial Insuffiency — Duration: 2 wks
Due to: Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Sidney D. Levy M. D.
Address 2302 Eastern Pkwy Date signed 2/1/46

G36983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G36983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 310 W Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Joyner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1926

8. AGE: Years 20 | Months - | Days 13 | If less than one day hr. min.

9. Birthplace Md - (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Joyner
13. Birthplace Md

MOTHER 14. Maiden Name Ethel Gamble
15. Birthplace Md -

16 (a) Informant Ethel Gamble
(b) Address 530 Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel -
Location

18 (a) Funeral director Adolphus Hailstead
(b) Address 918 Druid Hill Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 1 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 January 1946, at 10 40 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Toxemia

Due to 2° and 3° burns of back and both arms.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 13 January 11/4 1 00 P M.
(b) Where did injury occur? 310 W Preston St
(c) Did injury occur at home, on farm, industrial place, in public place? Gas Stove While at work?
(d) Means of injury Clothes caught afire

23. Signature William J. Kelbach M.D.
Medical Examiner
Date signed 31 January 46

X

636984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

636984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvia Casper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank Casper
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 29, 1925

8. AGE: Years	Months	Days	If less than one day
20	8	-	hr. min.

9. Birthplace Clinchol Va (Town, county, and state)
10. Usual Occupation Machine operator
11. Industry or business

FATHER
12. Name Reubern Robinson
13. Birthplace Va

MOTHER
14. Maiden Name Emma Stanley
15. Birthplace Va

16 (a) Informant Biffy Robinson
(b) Address Clinchola Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 1 1946 (Filed by registrar) Huntington [illegible] M.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest & Enquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h. on death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 29 at ~2:00 3/2 1946 M.
(b) Where did injury occur? 724 S. Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Asphyxiation by illuminating gas

23. Signature Robert Lee Fratkin M.D. Medical Examiner.
Date signed Jan 29th 1946.

G36985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

G36985

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 S. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Casper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sylvia Casper

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11/22/1908

8. AGE: Years 37 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Pittsburg
(Town, county, and state)

10. Usual Occupation Fireman Locomotive

11. Industry or business Engineer

FATHER
12. Name John Caspar
13. Birthplace Balto

MOTHER
14. Maiden Name Tina Jagroski
15. Birthplace Pittsburg

16 (a) Informant Mrs Otto Markle
(b) Address 623 S Robinson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans

19 (a) FEB 1 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946 at 12:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to carbon monoxide.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 27 at 23 E 3/3 1946 M.
(b) Where did injury occur? 724 S. Bond
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Asphyxiation by illuminating gas

23. Signature Robert L. Pretzman M.D.
Medical Examiner.
Date signed 1-29-46

VS 151

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

636986
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hospital 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 E. Lombard st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Hungary

3 (a) **FULL NAME** Steve Zagiba (ZAGIBA)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1888

8. AGE: Years	Months	Days	If less than one day
57	7	26	hr. min.

9. Birthplace Hungary (town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name John Zagiba
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary Vincz
15. Birthplace Hungary

16 (a) Informant Mercy Hospital
(b) Address Saratoga + Calvert Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meamber Son
(b) Address 805 North Calvert street

19 (a) (Date received by Registrar) FEB 1 1946 (b) Filed Hunting Toc Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1946, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Jan 30 1946, and that I last saw h. alive on Jan 30 1946.

Immediate cause of death	Duration
Pneumonia	3 wks
Due to Chronic Lymphoid Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Milton Linthicum M. D.
Address Mercy Hosp. Date signed 1/30/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36987

AB-31097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36987

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs-9mos- 6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Koehlert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16- 1872

8. AGE: Years	Months	Days	If less than one day
73	5	14	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Pharm.
11. Industry or business

FATHER
12. Name Henry Koehlert
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Roths
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Fredrick Road

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) Feb 1 1946 Huntington Williams, M.D.
(Entered by registrar) (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 19 46 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24- 19 38, to 1-30 19 46, and that I last saw h im alive on 1-30- 19 46.

Immediate cause of death	Duration
Cardiac failure	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B C H. Date signed 1/31/46

VS 150

X

Herbert A. Sarsfield

G36988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

36988 ✓ 108 Registered No. G36988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. FOR BINDING MARGIN RESERVED

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 48 Market Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert A. Sarsfield ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lenora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1901

8. AGE: Years	Months	Days	If less than one day
44	10	18	hr. min.

9. Birthplace Berlin, Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leonard Sarsfield
13. Birthplace Mass.

MOTHER
14. Maiden Name Mabel Wheeler
15. Birthplace Mass.

16 (a) Informant Mrs Lenora Sarsfield
(b) Address 48 Market Place

17 (a) Burial (b) Date thereof 2/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Baltimore, Md

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul Street

19 (a) FEB 1 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1946, at 12 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ~~accident~~ ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia, left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Ten Eyck Graham M.D.
Medical Examiner.
Date signed Jan. 28 1946

X

G36989 KRUL G36989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — DO NOT WRITE IN SPACES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Adam J. Krul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1923

8. AGE: Years 22 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Thomas Krul

13. Birthplace Poland

MOTHER 14. Maiden Name Veronica Piechoska

15. Birthplace Baltimore Md.

16 (a) Informant Veronica Piechoska

(b) Address 10 S. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Dundalk Ave

18 (a) Funeral director John J. Duda

(b) Address 2[illegible] Hudson St.

19 (a) FEB 1 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 January 1946, at 1[illegible] M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Rheumatic Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] Medical Examiner M.D.

Date signed 31 Jan 46

G36990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 47

G36990
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ward, Thomas Benjamin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	15	hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Seafarer

FATHER
12. Name Augustus Ward
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Lawson
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 2/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sunny Ridge Cem.
Location Crisfield Md.

18 (a) Funeral director Bradshaw Funeral Home
(b) Address Crisfield Md.

19 (a) FEB 1 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1946, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1946, to Jan. 31 1946, and that I last saw him alive on Jan. 31 1946.

Immediate cause of death: Carcinoma of lung — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. Southworth M. D.
Address Marine Hospital Date signed 1/31/47

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G36991 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Elsinore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Elsinore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARGARET BASHORE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George K. Bashore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1880

8. AGE: Years 65 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace: Lilitz, Pa. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John M. Kissinger
13. Birthplace: Lancaster Co., Pa.

MOTHER
14. Maiden Name: Mary Bingeman
15. Birthplace: Pa.

16 (a) Informant: Mr. George K. Bashore
(b) Address: 2705 Elsinore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) FEB 1 1946 Hunter for Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30, 1946, at 11:15 P

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1943 to Jan 30 1946 and that I last saw h[illegible] alive on Jan 29 1946.

Immediate cause of death: Coronary Thrombosis — Duration
Due to: arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: F. H. Tonella M. D.
Address: 104 W Madison St Date signed Jan 31, 46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G36992 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2929 Ellicott Driveway
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 Ellicott Driveway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RACHEL ALVERTA BOSLEY

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Rankin Bosley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1860

8. AGE: Years 85 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Co
(Town, county, and state)

10. Usual Occupation --

11. Industry or business --

FATHER
12. Name Samuel Billingsley
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name - McClung
15. Birthplace Balto. Co.

16 (a) Informant Mr. Milton W. Bosley
(b) Address Bush & Nanticoke St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 1 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1946 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Jan 30 1946 and that I last saw her alive on Jan 30 1946.

Immediate cause of death Hypertensive Cardio-vascular disease — Duration ?

Due to Arteriosclerosis — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Sullivan M. D.
Address 2911 Garrison Blvd Date signed Jan 31-46

VS 150

G36993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1929

G36993

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 42 yrs. in U. S. of A.

3 (a) FULL NAME ANDREW DONOGHAN or DONIGHAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
84 83			hr. min.

9. Birthplace Kent, England (Town, county, and state)
10. Usual Occupation Spicknall - 855 Pierce St.
11. Industry or business

FATHER
12. Name James Donoghan
13. Birthplace Scotland

MOTHER
14. Maiden Name Ellen Griffin
15. Birthplace Scotland

16 (a) Informant Mr. Donald Simmons
(b) Address 4644 Marble Hall Rd.

17 (a) Burial (b) Date thereof 2/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem St. James Sem.
Location Butler Lothian, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Lothian, Md.

19 (a) FEB 1 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1946, at 10:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1946, to Jan. 31 1946, and that I last saw him alive on Jan. 30 1946.

Immediate cause of death Acute Pulmonary Edema — Duration

Due to Hypertension & Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris L. Steinberg M. D.
Address 410 N. Hilton St. Date signed 31 Jan 46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36994 Certificate 11. BALTIMORE CITY HEALTH DEPARTMENT ✓ G36994

CERTIFICATE OF DEATH 2000a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 658 Fairmount Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 658 Fairmount Ave W.
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Jerow

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race C
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1944

8. AGE: Years 1 Months 4 Days 30 If less than one day hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business None

MOTHER / FATHER
12. Name William Jerow
13. Birthplace Summerton, S. C
14. Maiden Name Hettie May Bennett
15. Birthplace Summerton, S. C

16 (a) Informant William Jerow
(b) Address 658 Fairmount Ave

17 (a) Burial (b) Date thereof Feb. 1 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 2/1/46 (Huntington Williams Mgr.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 3 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1946 to Jan 31 1946, and that I last saw [illegible] alive on Jan 31 1946

Immediate cause of death Marasmus
Due to Malnutrition

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy: —

Duration
4 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature R. W. Jeckling M.D.
Address 414 N. Gilmor Date signed 2/3/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G36995

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Aiken Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
9
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Aiken Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis (Frank) X. Metz

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Davidson
6 (c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.) May 2, 1857

8. AGE: Years: 67 | Months: 8 | Days: 28 | If less than one day: ######## hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Retired, Cigar Maker
11. Industry or business: Cigar Mfgr.

FATHER
12. Name: John Metz
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Catherine Metz
(b) Address: 1804 Aiken Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 2, 1946 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) 2/1/46 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30, 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to Jan 30 1946 and that I last saw him alive on Jan 30 1946

Immediate cause of death: Hypostatic Pneumonia — Duration: 1 Day
Due to: Contusions of Back — 3 Wks
Due to: ____
Other Conditions: ____
(Include pregnancy within 3 months of death)
Date of operation: ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ____
(b) Date of occurrence: ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury: ____

23. Signature: William J. Reamer M. D.
Address: 801 Mt. Holly Rd. Date signed: 2/3/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G36996 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 E. Lanvale Street
(c) Hospital or institution: 9 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 E. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank I. Nagle

3 (b) If veteran, name war None

3 (c) Social Security Account No. 717-07-7687

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Christine M. Cunningh

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) April 15, 1884

8. AGE: Years 61 | Months 9 10 | Days 16 | If less than one day ~~hrs.~~ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business P.R.R

FATHER
12. Name Charles Nagle
13. Birthplace Unknown

MOTHER
14. Maiden Name Bridget Fleming
15. Birthplace Ireland

16 (a) Informant Mrs. Christine M. Nagle
(b) Address 1721 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 2/1/46 (Date rec'd by registrar) (b) [illegible] for William H. Taylor, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1946, at 3 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5-1945 to 1-31-1946 that I last saw [illegible] alive on 1-30-1946.

Immediate cause of death: Coronary occlusion — Duration 11-5-45

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. B. Sybert M. D.

Address 107 Harford Rd. Date signed 2-1-46

VS 150 /

X

G36997 ✓ G36997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Rutland Avenue
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Rutland Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas P. O'Neil

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-14-9944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret A. Larkin
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 25, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	6	hr. min.

9. Birthplace Dunmore, Pennsylvania (Town, county, and state)
10. Usual Occupation Bar-tender
11. Industry or business Tavern

FATHER
12. Name Patrick O'Neil
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Hawley, Pennsylvania

16 (a) Informant Mrs. Margaret A. O'Neil
(b) Address 1723 Rutland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Ce
Location Balto. City
18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue
19 (a) 2/1/46 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 20

20. DATE OF DEATH Jan. 31st 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Jan. 31 1946 and that I last saw him alive on Jan. 30 1946

Immediate cause of death Coronary Thrombosis — Duration 1 hr.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature H. B. Schneider M. D.
Address 541 S. Fulton Ave Date signed 1-31-46

VS 150

X

G36938 BALTIMORE CITY HEALTH DEPARTMENT G36938

CERTIFICATE OF DEATH 164c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ORIGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Nicholas Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Eikenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W. T.	WIDOWER

6 (b) Name of husband or wife EMMA A. EIKENBERG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 16 1900

8. AGE: Years	Months	Days	If less than one day
46	0	15	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business

FATHER
12. Name AUGUST EIKENBERG
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name ANNAPUETZ
15. Birthplace BALTIMORE MD.

16 (a) Informant GEORGE EIKENBERG (SON)
(b) Address 4215 NICHOLAS AVE.

17 (a) BURIAL (b) Date thereof FEB. 4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Tilly & Zeiler inc.
(b) Address 404 S. WOLFE ST.

19 (a) (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JAN. 31 1946, at 5/45 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of head
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 31 1946 M.
(b) Where did injury occur? 4215 Nicholas Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury pistol

23. Signature Benedict Skiatski M.D.
Medical Examiner.
Date signed 1-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G36999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 346 S. MACON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 346 S. MACON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE A. LEIKAM

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) SEPT. 11 1889
8. AGE: Years 56 Months 4 Days 18 If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WORK AT HOME
11. Industry or business AT HOME

FATHER
12. Name JOSEPH LEIKAM
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY OTT
15. Birthplace GERMANY

16 (a) Informant EVA HENNING
(b) Address 346 S. MACON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 2/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.
19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JAN. 30 1946, at 11/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1941 to Jan 30 1946 and that I last saw h[illegible] alive on Jan 29 1946.

Immediate cause of death: Pneumonia - Bilateral
Chr. Myocarditis
Due to: Myocardial Failure

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:

of autopsy: None

Duration
5-10-41
1-24-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 842 S. Eaton Ave Date signed 1-31-46

VS 150

X

G37000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G37000

107

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Southern Hotel
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town N. Y. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2847 Webb, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Capt. Edward Lee Dale

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Evelyn S. Dale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/18/1895

8. AGE: Years	Months	Days	If less than one day
50	6	13	hr. min.

9. Birthplace New Haven Ill. (Town, county, and state)
10. Usual Occupation Ship Captain
11. Industry or business

FATHER
12. Name Edward Lee Dale
13. Birthplace Ill.

MOTHER
14. Maiden Name Hattie McGee
15. Birthplace Ill.

16 (a) Informant Mrs. Evelyn S. Dale
(b) Address 2847 Webb, Ave N.Y.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/46 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat. Cem'y
Location Washington, D. C.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw, Place

19 (a) FEB 1 1946 (Date rec'd by registrar) (b) Interment for Military Service

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1946 to Jan 31 1946, and that I last saw [illegible] alive on Jan 31 1946

	Duration
Immediate cause of death Acute Dilatation of Heart.	Sudden
Due to Bronchial Pneumonia	
Due to A Pleurisy	10 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Leibenberg M. D.
Address 708 E. Monument Date signed 2/1/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37001

DEPARTMENT

CERTIFICATE OF DEATH 94a

G37001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFETIME

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Chesley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Wievard

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-9852

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife JENNIE I.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 9/11/1884

8. AGE: Years 61 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation ENGINEER

11. Industry or business

FATHER
12. Name CHARLES WIEVARD
13. Birthplace GERMANY

MOTHER
14. Maiden Name DORA ROSE
15. Birthplace GERMANY

16 (a) Informant MRS. J. I. WIEVARD
(b) Address 3407 CHESLEY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2 3 1946 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location BALTO. COUNTY

18 (a) Funeral director A. REILEY SLADE
(b) Address 4907 YORK RD.

19 (a) FEB 1 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1946, at 1 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec'd death on the day stated above; and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in pub place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.
Date signed 1-29-46

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3,002 ✓ 937 G3,002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 Foster Ave.
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Foster Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ALEXANDER McQUADE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Madora McQuade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1858.

8. AGE: Years	Months	Days	If less than one day
87	10	30	hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name James H. McQuade
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Ann Wheeler
15. Birthplace Maryland.

16 (a) Informant Mae Burke (Daughter)
(b) Address 3101 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-46. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave. Rd. Bal. Co.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 1 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31- 1946 at 7.22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4th 1946. to Jan. 30th 1946. and that I last saw her alive on Jan 30th 1946.

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerotic

Due to myocardiac degeneration of the Heart

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Couple
of
Months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kare Tramont M. D.
Address Lombard & Broadway Date signed 2-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63,003 ✓ 63,003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Laurel Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes B. Mrs Laue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	widowed

6 (b) Name of husband or wife ←

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd 1862

8. AGE: Years	Months	Days	If less than one day
83.	6	28	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name Bryan Healy
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Purcell
15. Birthplace Ireland

16 (a) Informant Mr. Francis J. McLaye
(b) Address 3612 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 9603 Hollins St

19 (a) FEB 1 1946 (b) Registrar Huntington Williams, M.D.
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/ 1946, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16 1946 to 1/31 1946 and that I last saw her alive on 1/21 1946.

Immediate cause of death	Duration
Terminal pneumonia	
Due to Partial left cerebral hemorrhage	
Due to H.C.V.D. —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Jones M. D.
Address Maryland Gen. Hospital Date signed 1/31/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37004 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 Towson ST
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Towson ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Faustyna Grodzicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Frank Grodzicki
(b) Address 1432 Towson ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto md.

18 (a) Funeral director George A Weber
(b) Address 705 S Ann st

19 (a) (Signature of) registrar (b) FEB 1 1946 Actg for Wilton M Hill Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1st 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Feb 1 1946, and that I last saw h[illegible] alive on Jan 31 1946.

Immediate cause of death	Duration
Cerebral apoplexy.	
Due to —	
Due to —	

Other Conditions Arteriosclerosis, hypertension, myocarditis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Schwend
Address 1337 S Charles Date signed 2/11/46

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637005 D-18973 546

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

637005 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4909 Benton Heights Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4909 Benton Heights ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Adams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased. (mo., day, yr.) Feb. 13-1945

8. AGE: Years | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Walter Joseph Adams

FATHER 13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Helen Withowzki

MOTHER 15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs Helen Adams

(b) Address 4909 Benton Heights ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore Co, Md

18 (a) Funeral director George R Weber

(b) Address 705 S. Ann St

19 (a) (Date rec'd by registrar) FEB 1 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31st 1946, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26, 1946, to Jan 31 1946, and that I last saw him alive on Jan 30, 1946

Immediate cause of death: Bronchial Pneumonia — Acute Heart Failure — Duration 2 days months

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Laufman M. D.

Address 4935 Baltimore Rd Date signed Jan 31, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37006

CBK-98795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G37006 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Moraley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Louis Jackson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 18-1880

8. AGE: Years	Months	Days	If less than one day
65	11	10	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Jackson
13. Birthplace Virginia

MOTHER
14. Maiden Name Dody ?
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2 2 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) FEB 1 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946, at 2:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1946, to Jan. 28 1946, and that I last saw h. in alive on Jan. 28 1946.

	Duration
Immediate cause of death (a) Uremia	1 week
Due to (b) Hypostasis, Bilateral	3 mos.
Due to (c) Benign Prostatic Hypertrophy	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury None
23. Signature Rush B. Nottingham M. D.
Address Baltimore City Date signed Feb 1 46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3,007 Mch No

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G3,007

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E Monument Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Elaine Ann Dittmar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16/46

8. AGE: Years — | Months — | Days 14 | If less than one day — hr. — min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Jacob Dittmar
13. Birthplace Baltimore

MOTHER 14. Maiden Name Anita Eleanor Arndt
15. Birthplace Baltimore

16 (a) Informant Burial 2/1/46
(b) Address

17 (a) Burial (b) Date thereof 2/1/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Greenlawn
Location Moreland Park - Baltimore Md

18 (a) Funeral director H.P. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

BV 1946 vs 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16-46 19 to 1-30-46 19, and that I last saw h[illegible] alive on 1-30-46 19

Immediate cause of death	Duration
Bronchopneumonia -	14 days
Pulmonary Edema	
Due to Atelectasis	
Due to	
Other Conditions Congenital Stenosis of ureters	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Diagnoses as stated above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Noguera M. D.
Address Maryland Gen. Hosp. Date signed 2-1-46

G37003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37003 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mieler Zeal

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Edward Zeal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1860

8. AGE: Years	Months	Days	If less than one day
85	8 9	29 2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name John Mieler
13. Birthplace Germany

MOTHER
14. Maiden Name Rose ?
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Stby

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ruth Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date received by registrar) (b) Registrar

FEB 1 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 8-48 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946, to Jan 31 1946, and that I last saw h[illegible] alive on Jan 31 1946.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Arterio Sclerosis	6 yrs
Due to	
Other Conditions Chronic Myocarditis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North Av Date signed 2/1/46 M. D.

G37009 ✓ G37009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 St Charles (If rural give location)
1431 St Charles
(e) Citizen of foreign country? ~~Yes~~ (Yes or No)
If yes, name country .....

3 (a) FULL NAME John W. Lambdin

3 (b) If veteran, name war ~~—~~

3 (c) Social Security Account No. 215-05-8123

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Laura V. Lambdin (nee Lebler)

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1889

8. AGE: Years 56 | Months 1 | Days 2 | If less than one day .....hr. .....min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation maintenance man

11. Industry or business H. O. Meyer Co., Inc.

FATHER
12. Name Henry Lambdin
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elizabeth Frederick
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Laura V. Lambdin (Wife)
(b) Address 14315 Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) 1946 (Date rec'd by registrar) (b) Irvington, Williamsburg, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30th 1946, to Jan 31st 1946, and that I last saw him alive on Jan 31st 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Pulmonary edema	
Due to C.V. Disease -	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature C. E. Gonzalez

Address Maryland General Hospital Date signed 1/31/46 M.D.

Gonzalez ×

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 B

Registered No. G37020

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 W. Heath St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (30)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 W. Heath St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma E. Hartline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leonard Hartline

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) June 3, 1884

8. AGE: Years 61 | Months 7 | Days 27 | If less than one day: hr. min.

9. Birthplace Jersey City, N.J. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Frederick Taube

13. Birthplace Germany

MOTHER — 14. Maiden Name Elizabeth Schneider

15. Birthplace Balto., Md.

16 (a) Informant Leonard Hartline (Husband)

(b) Address 2 W. Heath St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2, 1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director C. Howard Evans

(b) Address 1400 S. Charles St., Balto. 30, Md.

19 (a) FEB 1 1946 (Date rec'd by registrar) (b) Lexington Williams (Registrar)

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1946, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1945 to Jan. 30 1946 and that I last saw her alive on Jan. 29 1946

Immediate cause of death: Angina Pectoris — Duration 3 hrs

Due to: Hypertension — 1 yr

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Randall M.D.

Address 6 E. Read Date signed Feb. 1, 1946

E. Randall

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G37011

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1. 1861

8. AGE: Years	Months	Days	If less than one day
84	3	30	hr. min.

9. Birthplace Bedford County Pa.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John O'Farrell
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Farrell
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street Baltimore

17 (a) Burial (b) Date thereof Feb 7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Shrewsbury Cem.
Location Mt. Shrewsbury Pa.

18 (a) Funeral director H. Bankard Inc.
(b) Address Westminster Md.

FEB 2 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 31 1946, and that I last saw her alive on Jan 31 1946

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Arterio-Sclerosis	8 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed Feb 1-46

VS 150

X

63701 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 63701 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ORIGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Laurens Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 W. Pratt Street (If rural, give location)
(e) Citizen of foreign country? No, (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Wm. Hoffmann Wilhelm Friedrich Hoffmann

3 (b) If veteran, name war None

3 (c) Social Security Account No. 219-10-8397

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Clara Z. Hoffmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1874

8. AGE: Years 71 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Manager

11. Industry or business H. Wijo & Son

FATHER 12. Name John Matthew Hoffmann

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Marie M. Kopfman

MOTHER 15. Birthplace Germany

16 (a) Informant Clara Zahl Hoffmann

(b) Address 2015 W. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick Avenue

19 (a) Date rec'd by local registrar FEB 2 1946 (b) Registrar Huntington Millington M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1946, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, found that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 1-31-46

G37013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G37013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Memorial Hosp 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Samuel Summers Field

3 (b) If veteran, name war: W. W. #1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs S. S. Fields

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-5-1894

8. AGE: Years 47 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation Telephone Supervisor

11. Industry or business

FATHER
12. Name Samuel Field
13. Birthplace Virginia

MOTHER
14. Maiden Name Marie W. Crook
15. Birthplace Maryland

16 (a) Informant Mrs S. S. Field
(b) Address 2233 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) Date received FEB 2 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 1 - 1946, at 7 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1946 to Feb 1 1946, and that I last saw h[illegible] alive on Feb-1-1946.

Immediate cause of death	Duration
Carcinoma of Liver	
Due to	
Due to	
Other Conditions Hypertension Cardiovascular Dis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Carcinoma of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Fahnestock M. D.
Address Date signed 2/5/46

VS 150

X

637014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

637014 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 N. Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 N. Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. McCusker

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed or divorced~~: Married
6 (b) Name of ~~husband or~~ wife: Carrie W. McCusker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1875

8. AGE: Years	Months	Days	If less than one day
70	8	0	hr. min.

9. Birthplace Latrobe, Pa.
(Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business Asst. City Solicitor

FATHER
12. Name: Joseph McCusker
13. Birthplace Md.

MOTHER
14. Maiden Name: Mary Craig
15. Birthplace Md.

16 (a) Informant Carrie W. McCusker
(b) Address 615 N. Luzerne Ave

17 (a) Burial (b) Date thereof 2/4/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) FEB 2 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Jan 31 1946.
and that I last saw ~~him~~ alive on Jan 31 1946

Immediate cause of death: Arteriosclerosis — Duration: 4 Yrs

Due to

Due to

Other Conditions: CHRONIC NEPH — 2 YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Kavanagh M.D.
Address 3 E. Mt. Vernon Pl. Date signed 2-1-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

637015 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 562 Dragon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Niemann (John J. Niemann)

3 (b) If veteran, name war: N
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dora A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1876

8. AGE: Years 69 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business C & P.

FATHER
12. Name Henry Niemann
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Germany

16 (a) Informant Dora A Niemann
(b) Address 562 Dragon Ave Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Pulhom Cook Co
(b) Address 1217 E Cold St

1946 FEB 2 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1946 to Jan 31 1946 and that I last saw h[illegible] alive on Jan 31 1946

Immediate cause of death: Uremia of Trauma — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1/31/46

Major findings of operation: Uremia of Trauma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Calvary de Chaumont M. D.
Address 1/31/46 Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G37016 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Eutaw (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C Smith

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 218-09-1895

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 9 1892

8. AGE: Years: 53 | Months: 4 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Cleveland Ohio (Town, county, and state)

10. Usual Occupation: Laundry

11. Industry or business: Coal & Automobile

FATHER 12. Name: William J. Smith

FATHER 13. Birthplace

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant: Mrs Margaret Smith

(b) Address: 517 N Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 5 46 (month) (day) (year)

(c) Cemetery or crematory: Mt Olivet

Location: Baltimore Md

18 (a) Funeral director: Tillman

(b) Address: 1217 E Fort Ave

19 (a) Date received by registrar: FEB 2 1946 (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1946, at 1 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1946, to 1/31 1946, and that I last saw h[illegible] alive on 1/31 1946.

Immediate cause of death	Duration
Cachexia	
Due to: Carcinoma of	
Due to: Gallbladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1/21/46

Major findings of operation: Confirmatory

of autopsy: 1/31/46 Confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible]

Address: Md. Gen. Hosp. Date signed 1/31/46 M. D.

G3701?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1701

G3701?

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) If hospital or institution: South Balto General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. Henrietta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard S Price

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	220-05-1192

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lula
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1891

8. AGE: Years	Months	Days	If less than one day
55	1		hr. min.

9. Birthplace Combridge Md
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Grundal Co

FATHER
12. Name Wilhom T Price
13. Birthplace Md

MOTHER
14. Maiden Name Sarah M Linn
15. Birthplace Md

16 (a) Informant Sarah M Price
(b) Address 29 E Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Md
Location Glen Dwent Md

18 (a) Funeral director Wilhom Lee Inc
(b) Address 1211 E Pont St

19 (a) Date rec'd by registrar FEB 2 1946 (b) [illegible] M.D.

MEDICAL CERTIFICATION 65

20. DATE OF DEATH Feb. 1st 1946, at 1 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture, extracranial hemorrhage.
Fracture of 4th + 6th rib left
Cond. with rupture of lung.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22-1
(a) Date of injury 1/28/46 1:30 P.M.
(b) Where did injury occur? Lee + West Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by auto.

23. Signature Benedict Stasiulis M.D.
Medical Examiner.
Date signed 2-1-46

VS 151

G37018 HEALTH DEPARTMENT—CITY OF BALTIMORE G37018

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Ramsay St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Anna Pattison

If U. S. Veteran specify WAR

(a) Residence: No. 913 Ramsay St. 21-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Pattison

6. DATE OF BIRTH (month, day, year) May 10 1884

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	8	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Sandusky Ohio

FATHER

13. NAME Reyin Franklin

14. BIRTHPLACE (city or town) (State or country) Baltimore Md

MOTHER

15. MAIDEN NAME Anne Pichet

16. BIRTHPLACE (city or town) (State or country) Baltimore Md

17. INFORMANT Clinton M Ashby

(Address) 1140 N Monroe St

18. BURIAL, CREMATION, OR REMOVAL

Place Morgan Chapel Date Feb 4, 1946

19. UNDERTAKER William Cook Inc

(Address) 1217 St Paul Street

20. FILED FEB 2 1946 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 31, 1946

22. I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1946, to Jan. 31, 1946

I last saw her alive on Jan. 31, 1946 Death is said to have occurred on the date stated above, at 9.05 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of death
Cerebral Hemorrhage	29 Jan. 46
Hypertensive Cardio-vascular disease	3 yrs. duration
Other contributory causes of importance	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Benjamin Highstein M. D.

(Address) 124 S. Highland Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Examine items of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

VS 8

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. G37019

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md General Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 408 Bretton Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miah E, Seitz

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1872

8. AGE: Years	Months	Days	If less than one day
73	5	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired School Teacher

11. Industry or business Balto. City

FATHER
12. Name John W. C. Seitz
13. Birthplace Pa.

MOTHER
14. Maiden Name Martha Lewis
15. Birthplace Frederick, Md.

16 (a) Informant Mr. Berton R. Potter
(b) Address 408 Bretton Place

17 (a) Burial (b) Date thereof 2/4/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 2 1946
(Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 19 46 at 5:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Massive pulmonary embolus

Due to

Other Conditions Fracture of left femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/6/46 at 12/4 P. M.
(b) Where did injury occur? St Paul & 22nd St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Struck by auto.

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2-1-46

G370c0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G370c0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Roland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12+1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OSCAR CUNNINGHAM

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Cairnes Cunningham
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/20/1873
8. AGE: Years 72 | Months 4 | Days 11 | If less than one day hr. min.
9. Birthplace York Co., Pa.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business U. S. Post Office

FATHER
12. Name Robert Cunningham
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Martha Brooks
15. Birthplace Pa.

16 (a) Informant Mrs. Cornelia Seward
(b) Address 1511 E. 35th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Harford Co., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date filed by Registrar FEB 2 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1946 at 11:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7/1930 19 to 1/31/46 19, and that I last saw him alive on 1/31/46 19

Immediate cause of death	Duration
Coronary Occlusion, Acute.	Sudden.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jarvis M. D.
Address 11 E. Chase St. City-2 Date signed 2/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37021 G37021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1?87

8. AGE: Years 59 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Lineman & Inspector

11. Industry or business

FATHER
12. Name Kirk Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Leila Hatch
15. Birthplace Va.

16. (a) Informant Mrs. James D. Hull
(b) Address 2403 Lyndhurst

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Friends
Location Harford Rd. Balto. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Hill Registrar

VS FEB 2 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/46 19 at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1945 to 1/31 1946. and that I last saw h[illegible] alive on 1/31 1946

Immediate cause of death Cardio-Resp. failure — Duration

Due to Acute Heart Failure

Due to

Other Conditions Bronchitis Hypostatic (Including pregnancy within 3 months of death)

Date of operation 1/27

Major findings of operation Pneumonia Bronchitis Hypostatic

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. M. Scott

Address University Hospital Date signed 2/1/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

63702 63702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. 63702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary Duvall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/14/84

8. AGE: Years 61 | Months 8 | Days 4 | If less than one day hr. min. 27

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name —
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Mrs. Doris Glenn
(b) Address 164 N. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Milton Ave & Rose St.

18 (a) Funeral director Howard M. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31-46 19 , at 8:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1945 to 1-31 1946, and that I last saw h.e.r. alive on 1-31 1946

Immediate cause of death: Toxiemia due to GAS GANGRENE — Duration

Due to: GANGRENE of leg

Due to: Arteriosclerosis - Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address St. Joseph's Date signed 1/31/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3703 BALTIMORE CITY HEALTH DEPARTMENT G3703

CERTIFICATE OF DEATH 180 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Scene of fire:
(b) Street address 5217 Belair Rd.
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick P. Klebsuner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie E.

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 5, 1882

8. AGE: Years 63 64 | Months 10 | Days 1 26 | If less than one day ..... hr. ..... min.

9. Birthplace Fullerton, Maryland (Town, county, and state)

10. Usual Occupation Lt. City Nurse

11. Industry or business Department

FATHER 12. Name John Klebsuner

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Marie E. Klebsuner

(b) Address 4006 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/46 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director Howard N. Blight

(b) Address 4914 Belair Road

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

FEB 2 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 1946, at 10 40 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 3rd° burns involving 90% of body surface

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2/1/46 at 26/2 10:30 P.M.

(b) Where did injury occur? Scene: 5217 Belair Rd.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes

(d) Means of injury Caught in burning building

23. Signature Benedict Skotarski M.D. Medical Examiner

Date signed 2-2-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G37064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Virginia Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME W. Malcolm Moore 3

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 220-03-3420

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of ~~husband~~ or wife Kathryn T Moore 3
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1909

8. AGE: Years	Months	Days	If less than one day
36	10	4	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation Employment Manager
11. Industry or business

FATHER
12. Name George O Moore 3
13. Birthplace Maryland

MOTHER
14. Maiden Name Katharine Zeigenhein
15. Birthplace Maryland

16 (a) Informant Kathryn T Moore 3
(b) Address 3210 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Walter Boyd Bradley
(b) Address 1922 W. North ave.

19 (Registered by) FEB 2 1946 (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 1 - 1946, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 - 1946, to Feb - 1 - 1946, and that I last saw h.z.me alive on Feb - 1 - 1946

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Polycystic Kidneys	
Due to Hypertensive Cardio-vascular Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George T. Schlenger M. D.
Address Date signed 2/3/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37035 G37035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: FRANKLIN SQUARE HOSP. 23
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS HAMLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Phoebe E. Hamlin (nee Trippe) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1872

8. AGE: Years: 73 | Months: 4 | Days: 11½ | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER — 12. Name George J. Hamlin
13. Birthplace Balto Md

MOTHER — 14. Maiden Name Elizabeth Spring
15. Birthplace England

16 (a) Informant John P. Hamlin (Son)
(b) Address 1612 S. Charles St Balto 30, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto Md.

18 (a) Funeral director A. Howard Evans
(b) Address 4005 Charles St, Balto 18, Md

19 (a) (Date received) (b) Huntington Williams (Registrar)

FEB 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 JAN 1946, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 JAN. 1946, to 31 JAN 1946, and that I last saw h/m alive on 31 JAN 1946

	Duration
Immediate cause of death: HYPERNEPHROMA, L. KIDNEY WITH	
Due to METASTASIS TO LUNGS	2 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy HYPERNEPHROMA, L. KIDNEY

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bailey L. Jones M. D.
Address Franklin Sq. Hosp. Date signed 2/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 6350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2938 St Paul St
(c) Hospital or institution at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2938 St Paul (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Frederick Charles Backus

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charlotte G. Backus

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 25 1878

8. AGE: Years 67 | Months 7 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Detroit Mich. (Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business U.S. Auto Supply Co

FATHER
12. Name Theo. L. Backus
13. Birthplace Detroit Mich

MOTHER
14. Maiden Name Anna L. Frisk
15. Birthplace Troy N.Y.

16 (a) Informant Mrs Charlotte G. Backus (wife)
(b) Address 2938 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Elliott City

18 (a) Funeral director Stewart & Company
(b) Address 108 W Saratoga St

19 (a) FEB 2 1946 (b) Registrar
Date rec'd by Registrar

Huntington Hitchcock

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1946 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to June 30 1946, and that I last saw him alive on June 28 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Arteriosclerosis and Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Dwyer M.D.
Address 304 W Franklin St Date signed 2/1/46

X Laboratory

G37027

G37027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER STS
(c) Hospital or institution:
ST JOSEPH'S HOSP. 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 58 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4252 NICOLAS AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LETTIE F. SCHAEFER (LETTIE FLOYD SCHAEFER)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: JOHN H. SCHAEFER

6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): 9-17-77

8. AGE: Years: 68 | Months: 4 | Days: 13 14 | If less than one day: hr. min.

9. Birthplace: Richmond, VA.
(Town, county, and state)

10. Usual Occupation: HOUSE

11. Industry or business:

FATHER — 12. Name: Robert Taylor
13. Birthplace: Virginia

MOTHER — 14. Maiden Name: ? Gager
15. Birthplace: Virginia

16 (a) Informant: Mr. John H. Schaefer
(b) Address: 4252 Nicholas Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

FEB 2 1946 (Date received) (b) Registrar: Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 1946, at 4 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1946 to 2-1 1946 and that I last saw her alive on 2-1 1946

Immediate cause of death	Duration
Ruptured left ventricle	
Due to Coronary infarct	
Due to Coronary occlusion	
Other Conditions Atrophic left Kidney	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: infarct L. Ventricle Coronary occl.

of autopsy Atroph. Art. sclr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Wells M. D.
Address St Jos Hosp Date signed 2-1-46

VS 150

John B. Wells 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63708 Female

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

63708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1440 E. Monument st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1440 E. Monument st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Julius Williams
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Etta Mealey
15. Birthplace Balto, Md.

16 (a) Informant Etta Williams
(b) Address 1440 E. Monument st.

17 (a) Burial (b) Date thereof 2-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson st.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 2

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1, 1946, at 11.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1946 to Feb 1, 1946, and that I last saw h[illegible] alive on Feb 1 1946

Immediate cause of death Congenital Atelectasis — Duration 1 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Barnwell M.D.

Address 121 Cequid St Date signed Feb 1, 46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

63,039 | BALTIMORE CITY HEALTH DEPARTMENT | 63,039

CERTIFICATE OF DEATH 206

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Milliman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Milliman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur W. Snyder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1890

8. AGE: Years	Months	Days	If less than one day
55	6	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Snyder
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Edith Kirby
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Katherine Snyder
(b) Address 2329 Milliman St.

17 (a) Burial (b) Date thereof Feb. 4, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Balto. Md.

18 (a) Funeral director Otho Jo Howington Sons
(b) Address 2024 Orleans St.

19 (a) (b) Registrar
(Date received by registrar)

FEB 2 1946 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1946 to 1/31 1946
and that I last saw him alive on 1/30 1946

Immediate cause of death Coronary Occlusion — Duration 1 day
Due to Luetic Myocarditis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph P. Kokorey, M.D.
Address 2200 E. Madison St. Date signed 2/1/46

X

G37030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120a

Registered No. G37030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 EDMONSON AVENUE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Edmondson Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EMMA HENDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: COLORED

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: WILLIAM

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT, 5, 1913

8. AGE: Years 32 30 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace DINWIDDIE CO, VIRGINIA (Town, county, and state)

10. Usual Occupation DOMESTIC

11. Industry or business

FATHER
12. Name ARCHIE RANDOLPH
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name MARTHA JEFFERSON
15. Birthplace VIRGINIA

16 (a) Informant MARTHA JAMES
(b) Address 813 N. CALHOUN STREET

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-46 (month) (day) (year)
(c) Cemetery or crematory MT. Calvary
Location Anne Arundel Co., Maryland

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 Penna., Ave.

FEB 2 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9/ 1946, to 1/30/ 1946, and that I last saw h.... alive on 1/30/ 1946.

Immediate cause of death Coronary Occlusion
Dilatation of stomach
Due to Gastro-enteritis
with dehydration & anemia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maylands Jones
Address 1300 N. Fremont Date signed 2/1/46

VS 150

63031 Not Issued

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

63031 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Bellevue Ave #12
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/46

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hr. 30 min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name George L. Smith
13. Birthplace —

MOTHER
14. Maiden Name Mary McFarland
15. Birthplace Va

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Feb 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Peters
Location Baltimore

18 (a) Funeral director George A. Fowley
(b) Address Fulton Ave & Fayette St.

19 (a) FEB 2 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1946 to 1/31 1946, and that I last saw him alive on 1/31 1946

Immediate cause of death: Prematurity

Duration

Due to Placenta previa (Mother)

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David T. Bell, M.D.
Address Mercy Hospital Date signed 1/31/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63702 LEASURE 63702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hosp. 2-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Wolfe (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Leasure

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	28	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Emory Leasure
13. Birthplace N.Y.

MOTHER 14. Maiden Name Catherine Mc Gowen
15. Birthplace Ireland

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory XXXXX Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director C.E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 1125 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Jan 31 1946 and that I last saw him alive on Jan 4 1946

Immediate cause of death	Duration
Cardia - resp. failure	
Due to Congestive heart failure	
Due to Hypertension & V Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Milton Leatherman M. D.
Address Mercy Hosp. Date signed 1-31-46

FEB 6

V9 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37033 — BALTIMORE CITY HEALTH DEPARTMENT — G37033

CERTIFICATE OF DEATH 1925 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 Orleans street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 S. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FELIKSA ROGOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Dominik

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1875

8. AGE: Years 70 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Stanislaus Chojnowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Walinski
15. Birthplace Poland

16 (a) Informant Mrs Stella Pawlak (Daughter)
(b) Address 314 S. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 4 46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John Jr. Weber
(b) Address 401 S. Chester Street

19 (a) (b)
Date received by registrar FEB 2 1946 Registrar

VS 150

MEDICAL CERTIFICATION 9 15

20. DATE OF DEATH Jan 31 1946, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Jan 31 1946 and that I last saw h[illegible] alive on Jan 31 1946

Immediate cause of death Coronary Thrombosis — Duration 1/29/46

Due to Chr Endocard. Fib — 2/1945

Due to Arteriosclerosis — 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Rosner M. D.
Address 801 N Eutaw St Date signed 2/2/46

Huntington Williams, M.D.

X

63,034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

Registered No. 63,034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D OA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 W. Barre ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wade Harrell

3 (b) If veteran, name war

3 (c) Social Security Account No. 226-09-5322

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1915

8. AGE: Years	Months	Days	If less than one day
30	1	8	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Boston Iron works

FATHER
12. Name Stephen Harrell
13. Birthplace N.C

MOTHER
14. Maiden Name Ida Rocktack
15. Birthplace N.C.

16 (a) Informant Florence Harrell
(b) Address 634 W Barre Street

17 (a) Removal (b) Date thereof 2/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosemount
Location Suffolk Va

18 (a) Funeral director Daniel R Brown Sons
(b) Address 1080 Montgomery Street

19 (a) (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

FEB 2 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1946, at 1 05 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head, Crushed Chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25-5 20

(a) Date of injury Jan. 31 1946 12 P M.
(b) Where did injury occur? Curtis Bay, Boston Iron and Metal Works
(c) Did injury occur at home, on farm, industrial place, in public place? Accidental While at work? yes
(d) Means of injury Struck by crane boom

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 31 1946

G37035 AB-98911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg D 41276 145

G.37035 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs-45min.
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 Somerset St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Madeline Viole Meniefield or Menefield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26-1925

8. AGE: Years	Months	Days	If less than one day
20	7	4	hr. min.

9. Birthplace N.J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Meniefield or Menefield
13. Birthplace Ala.

MOTHER
14. Maiden Name Viola Brown
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/46 (month) (day) (year)

(c) Cemetery or crematory
Location FABER, VA

18 (a) Funeral director Elmer O. Wilson
(b) Address 1000 Brantley Ave

19 (a) FEB 2 1946 (Date rec'd by registrar) (b) Huntington Hillcrest Mort

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1946, at 5.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1946 to 1-30 1946 and that I last saw h ER alive on 1-30 1946

Immediate cause of death	Duration
Pulmonary Edema	
Acute Dilatation of Heart	
Due to	
Due to	
Other Conditions Pregnancy at term Delivered	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd Rees M. D.
Address Date signed 1/31/46

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MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G37036

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert
(c) Hospital or institution: MERCY
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4908 Akon Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Rosa Pessagno

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Late Dohn Pessagno
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1855

8. AGE: Years	Months	Days	If less than one day
90	3	17	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name John Paretti
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Mrs. Mary T. Pessagno
(b) Address 4904 Akon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4/46. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Old Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 401 E Lanvale Ave

19 (a) (Date rec'd by registrar) (b) Filington Hillcrest Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1/46 1946 at 10 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1946 to 2/1 1946. and that I last saw h[illegible] alive on 2/1 1946.

Immediate cause of death	Duration
Cachexia	
Auricular Fibrillation	6 days
Due to Arteriosclerotic	
C.V. Dis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex C. Killy Jr M. D.
Address Mercy Date signed 2/1/46

VS 150

LISSAU

G37037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. G37037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Caton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman St. Lissau

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband or~~ wife Maria Kuntz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3 1888

8. AGE: Years 57 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Baker (Retired)

11. Industry or business

FATHER
12. Name Richard Lissau
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine (unknown)
15. Birthplace Germany

16 (a) Informant Mrs Maria Lissau
(b) Address 3500 Caton Ave

17 (a) Burial (b) Date thereof Feb 4 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Rd (Washington Blvd)

18 (a) Funeral director Harry F Weyhe

(b) Address 4106 Edmondson Ave

19 FEB 2 1946 Huntington Philadelphia
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1946, at 11:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1946, to 1/30 1946, and that I last saw him alive on 1/30 1946

Immediate cause of death: Pulmonary Embolism — Duration

Due to: Cardiac failure

Due to: Hypertensive Cardiac — Vascular disease

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 1/23/46
Major findings of operation: umbilical hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Square Hosp. Date signed 1/31/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G37038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Aldershot Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H. Elliott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emma T

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 3, 90

8. AGE: Years	Months	Days	If less than one day
55	3	26 28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business —

FATHER
12. Name Louis Elliott
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Jardine
15. Birthplace Baltimore

16 (a) Informant Emma T. Elliott
(b) Address 611 Aldershot Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Smith
(b) Address 410 Edmondson Ave

19 (a) (b) Registered
(State registrar)

FEB 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1946, at 10 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1946 to 1/31 1946 and that I last saw him alive on 1/31 1946

Immediate cause of death Probable Embolic phenomena — Duration 1/2 hr

Due to Coronary Thromb 0315 — 8 days

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex B. Tully Jr. M.D.

Address Mercy Date signed 1/31

G37039 BALTIMORE CITY HEALTH DEPARTMENT G37039
CERTIFICATE OF DEATH
Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 Wyndhurst Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Wyndhurst Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maude M. Stewart

3 (b) If veteran, name war: M
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30 1874

8. AGE: Years	Months	Days	If less than one day
71	5	12	hr. min.

9. Birthplace Portsmouth Eng
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Nutty
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Harry A. Stewart
(b) Address 204 Wyndhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Pikesville Md

18 (a) Funeral director Gilbert & Orem
(b) Address 1219 E Fayette St

(Date received by registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1946 to Feb 2 1946 and that I last saw h Se alive on Feb 1 1946.

Immediate cause of death	Duration
Coronary Thrombosis	12 hrs
Due to	
Due to	
Other Conditions Diabetes Mellitus	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles O'Donovan M. D.
Address 5 East Read St Date signed 2 Feb 46

VS 150

Chas. O'Donovan 94a

G37040 B-04721 BALTIMORE CITY HEALTH DEPARTMENT G37040

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 N. Calvert ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lorraine E. Cobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1944

8. AGE: Years	Months	Days	If less than one day
1	6	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Cobbs

13. Birthplace Richmond Va.

MOTHER 14. Maiden Name Elizabeth Wolf

15. Birthplace Balto. Md

16 (a) Informant Samuel Cobbs

(b) Address 1809 N. Calvert st.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 2/4/46 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

19 (a) 1946 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1946, at 4:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hematoma, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/5

(a) Date of injury 1-31-46 at 7 P. M.

(b) Where did injury occur? 819 N. Calvert Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Fell off bed

23. Signature Robert Le Gratten M.D. Medical Examiner.

Date signed Feb 1 1946

G3701 ✓ G3701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Baltimore Hosp. Dor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Denver Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena S. Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Adam J. Roth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1868

8. AGE: Years	Months	Days	If less than one day
77	3	26	hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business: Self

FATHER
12. Name: William Bretslau
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louise Waterman
15. Birthplace: Germany

16 (a) Informant: Louise Lowman
(b) Address: 1113 Denver st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/5/46 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Western
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St Paul st.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2nd 1946, at 7:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry: thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Sestarelec M.D.
Medical Examiner.
Date signed 2-2-46

VS 151

X

Copy - (Original was lost) G3.0:2

BALTIMORE CITY HEALTH DEPARTMENT ✓ G3.0:2 Registered No.

CERTIFICATE OF DEATH 56D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & saratoga St
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 N Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sol Finkelberg

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-3769

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov, 20. 1903

8. AGE: Years	Months	Days	If less than one day
42	2	12	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Ship Yard

FATHER
12. Name Getzel Finkelberg
13. Birthplace Russia

MOTHER
14. Maiden Name Zelda Kaufman
15. Birthplace Russia

16 (a) Informant Mrs Morris Cohen
(b) Address 2026 N Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 3 1946

VS 150

MEDICAL CERTIFICATION 8.35

20. DATE OF DEATH February 2 1946, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1945 to Feb 2 1946, and that I last saw him alive on 2-2 1946.

Immediate cause of death: Cardio-Resp failure — Duration

Due to: Increased intra cranial pressure

Due to: Probable brain tumor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P.D. Stolan Jr (for H. Sanchez)

Address Mercy Hosp - Date signed 2/3/46 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37043 ✓ G37043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1038 Valley st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William V. Furlong

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Catherine B. Furlong (Maiden name) (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1884

8. AGE: Years	Months	Days	If less than one day
62		16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk B & O. R.R.
11. Industry or business B & O. RR

FATHER 12. Name Patrick Furlong
FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Murphy
MOTHER 15. Birthplace Ireland

16 (a) Informant Mrs. Catherine B. Furlong
(b) Address 1038 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 1946 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cemetery
Location Homewood Ave Catonsville

18 (a) Funeral director Edgar W. Conklin
(b) Address 924 E. Eager St.

19 (a) [illegible] (Registered by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31, 1946, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1946 to 1/31 1946, and that I last saw him alive on 1/30 1946.

Immediate cause of death	Duration
Acute coronary Thrombosis	
Due to Coronary Sclerosis	
Due to Chronic Myocardial Weakness	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M.D.
Address 733 Augusta Ave Date signed 2/1/46

HORNSTEIN X

VS 180

G3704 BALTIMORE CITY HEALTH DEPARTMENT G3704
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2918 Independence St
(c) Hospital or institution:
9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Independence St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse James Brent

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 220-12-7847

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ella Mae Davis Brent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1875

8. AGE: Years: 70 | Months: 8 | Days: 12 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation U.S. Welding Co. Laborer

11. Industry or business Mason

FATHER
12. Name Walter Brent
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Nancy Owens
15. Birthplace Quinns Mills Md.

16 (a) Informant Mr. Hubman F. Maxwell
(b) Address 2918 Independence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Washington Blvd. Mill

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 1946, at 5 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1946 to 2/1 1946 and that I last saw h. alive on 2/1 1946.

Immediate cause of death: Acute Cerebral Hemorrhage — Duration: 1 hr

Due to: Ch. arteriosclerosis

Due to: Ch. Hypertension

Other Conditions: Ch. hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. K. Thometz M. D.

Address 733 Augusta St. Date signed 2/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE RESERVED FOR BINDING

FEB 13 1946

VS 150

83a

63705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312a

63705 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Lakeland.
(c) Hospital or institution: West Baltimore Gen. Hosp. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Moreland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Walsky

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Anna Walsky
(b) Address 1712 Moreland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-46 (month) (day) (year)
(c) Cemetery or crematory: Bnai Israel
Location Loudon Ave

18 (a) Funeral director Jules Levin Inc
(b) Address 200 Eutaw Place

19 (a) 1946 (Date rec'd by registrar) (b) Interior Williams U.B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1946, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1946, to Feb 2 1946, and that I last saw him alive on February 2 1946.

Immediate cause of death: Circulatory Failure — Duration

Due to Chronic Congestive Failure

Due to Hypertension & C.V. Dis

Other Conditions Nephrosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leslie A. Hoffa M.D.
Address West Balto Gen Hosp Date signed 2/2/46

VS 150

63706 N-38580 63706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Evelyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Evelyn Ave
(Rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19-45

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry D. Cohen

13. Birthplace West Va.

MOTHER 14. Maiden Name Lucille Ramsdell

15. Birthplace Balto. Md.

16 (a) Informant Harry D. Cohen

(b) Address 3016 Evelyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1739 E. Balto St

19 (a) 1946 (b)
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2, 1946, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19, 1945 to Feb 2, 1946 and that I last saw h. alive on Feb 2, 1946

Immediate cause of death Congenital Heart

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Some Minutes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Asken

Address 2006 Parkam Date signed 2/4/46 M. D.

VS 150

63047 BALTIMORE CITY HEALTH DEPARTMENT 63047
CERTIFICATE OF DEATH 93D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4139 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4139 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Walter James Stalen

3 (b) If veteran, name war —

3 (c) Social Security Account No. 725-10-0554

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29-1885

8. AGE: Years 60 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name James A. Stalen
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah C. Childs
15. Birthplace Maryland

16 (a) Informant Mrs. Helen Farren
(b) Address Ruxton, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-4-1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 3 1946 (Date rec'd by registrar) (b) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1946, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to 2/1 1946 and that I last saw h[illegible] alive on 2/2 1946.

Immediate cause of death Ch. valv. Heart Dis. — Duration 4 yrs

Due to

Due to

Other Conditions C.V.D. Chr. I.D. Tobacco Hab. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald D[illegible]
Address 2020 N. Charles Date signed 2/3/46

VS 150

G370:8 G370:8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Salisbury (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond E. Hunt.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 712-14-8932

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife Ida B. Hunt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24-1891

8. AGE: Years 55 | Months — | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation Route Agent

11. Industry or business Railway Express

FATHER
12. Name George Hunt
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Edrington
15. Birthplace Virginia

16 (a) Informant Mrs. Ida B. Hunt
(b) Address Salisbury, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Feb. 5. 1946

(c) Cemetery or Crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 1946 (Date rec'd by registrar) (b) Wilson Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1 1946 at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1946 to 2/1 1946 and that I last saw h. alive on 2/1 1946

Immediate cause of death: Cardio-Respiratory failure — Duration

Due to Pulmonary Congestion

Due to Pulmonary metastasis from Carcinoma of Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene J. Riley, M. D.
Address 1400 N Caroline St Date signed 2/1/46

VS 150

G3709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G3709 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 3
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Basile

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Wd

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1883

8. AGE: Years 63 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace New York N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Mowerley
13. Birthplace N.Y.

MOTHER 14. Maiden Name Catherine Pye
15. Birthplace N.Y.

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 7/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Eastern Ave

18 (a) Funeral director L. HECKMANN & SON
(b) Address 32 S. BROADWAY

19 (a) (b)
(Date rec'd by registrar) Huntington Hall Registrar

FEB 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1946 at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30-1946 to 1-2-1946 and that I last saw him alive on 1-2-1946

Immediate cause of death Acute Pulmonary Edema — Duration

Due to Hypertensive arteriosclerotic CVD

Due to

Other Conditions: Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Slifer M. D.
Address Church Home & Hosp. Date signed 2-1-46

X

63,050 BALTIMORE CITY HEALTH DEPARTMENT 63,050

486620 CERTIFICATE OF DEATH 928 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Poggi
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Helen Poggi
6 (c) If alive, give age 22 years
7. Birth date of deceased (mo., day, yr.) 5-31-17.
8. AGE: Years 28 Months 8 Days 2 If less than one day hr. min.
9. Birthplace md. (Town, county, and state)
10. Usual Occupation blank.
11. Industry or business

FATHER
12. Name John Poggi
13. Birthplace Italy

MOTHER
14. Maiden Name Emma. Orangea.
15. Birthplace Washington D.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 (a) 1946 (Date rec'd by registrar) (b) Clayton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 - 1946, at 7.20 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan- 18- 1946, to Feb- 2- 1946, and that I last saw him alive on Feb- 2- 1946.

Immediate cause of death	Duration
PULMONARY EMBOLISM	2 DAYS
Due to INACTIVE RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS	14 YEARS
Due to AND INSUFFIENCY WITH CARDIAC FAILURE	
Other Conditions AURICULAR FIBRILLATION (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel P. Asper
Address Johns Hopkins Date signed Feb 7 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37051 BALTIMORE CITY HEALTH DEPARTMENT G37051
CERTIFICATE OF DEATH 479
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MILTON HOLMES

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 214-01-8526

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Jane Elizabeth Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1882

8. AGE: Years 63 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Traffic Dept.
11. Industry or business Revere Copper & Brass Co

FATHER
12. Name Edward Anderson Holmes
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden Name Elizabeth Harper Emmrich
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Elizabeth H. Lang
(b) Address 3306 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 3 1946 (Date rec'd by registrar) (b) Huntington White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1946, at 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1945 to Feb. 1 1946, and that I last saw h[illegible] alive on Feb 1 1946.

Immediate cause of death	Duration
Cardiac Arthma	1 da
Due to Carcinoma of Lung	5 mo
Due to Metastasis to Lymphatics	2 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury E. W. Kenny, M.D.
23. Signature E W Kenny MD
Address 1202 St Paul St Date signed Feb 3/46

VS 150

G37052 D-35263 BALTIMORE CITY HEALTH DEPARTMENT G37052

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. Scott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME John C. Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29th 1945

8. AGE: Years	Months	Days	If less than one day
0	3	0 4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name John C Miller
13. Birthplace Md.

MOTHER
14. Maiden Name Juanita Brown
15. Birthplace Md

16 (a) Informant Mother - Juanita
(b) Address 110 S. Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial P.K.
Location Ritchie Highway
18 (a) Funeral director John J. Bryant & Son
(b) Address 911-03 Hollins St
19 (a) 1946 (Date issued by registrar) (b) Victor Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1946 to 2-2 1946 and that I last saw h/m alive on 2-2 1946

Immediate cause of death	Interval between onset and death	Duration
Bronchopneumonia		5 days
Due to Suppurative Respiratory infection		2 mo.
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene A Harmon M.D.
Address Univ. Hosp. Date signed 2-2-46 M. D.

G37053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195 E

Registered No. G3[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5da
(e) Length of stay in Baltimore (yrs., mos., or days) 37yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 HAMPDEN AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EDMUND LEO FAHEY

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1908

8. AGE: Years 37 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Michael Joseph Fahey
13. Birthplace IRELAND

MOTHER 14. Maiden Name MARY Blake
15. Birthplace MARYLAND

16 (a) Informant MRS. MICHAEL J. FAHEY
(b) Address 2823 HAMPDEN AVE, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home Inc
(b) Address 1217 W. Lord St

19 (a) FEB 4 1946 (Date received by Registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1946 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30 1946 to 2-3 1946 and that I last saw him alive on 2-3 1946.

Immediate cause of death: SUBARACHNOID HEMORRHAGE — Duration:
Due to: TRAUMA ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: 2-3-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide: Unknown
(b) Date of occurrence: Jan 30 1946 at M
(c) Where did injury occur? Baltimore, Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury: Fell to Pavement

23. Signature: Thomas J. Kluskens, M.D.
Address U.M.H. Date signed 2-3-46

VS 150

G3704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G3704 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Herbert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Herbert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Angie Roda Tolford

3 (b) If veteran, name war
3 (c) Social Security Account No. nn

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph N.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17 1866

8. AGE: Years	Months	Days	If less than one day
79	9	15	hr. min.

9. Birthplace Carolina Co Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Tilson
13. Birthplace Caroline Co Md

MOTHER
14. Maiden Name Maggie Unknown
15. Birthplace Caroline Co Md

16 (a) Informant Mrs Sadie Price
(b) Address 6914 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Tilson Corbine
(b) Address 1217 St Paul St

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Feb 2 1946 and that I last saw him alive on Feb 2 1946

Immediate cause of death: Hypertensive Cardio vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis T. Leary

Address 1844 W. Lanvale Ave Date signed 2/3/46

VS 150

G3705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G3705

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 E 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida M Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1872

8. AGE: Years	Months	Days	If less than one day
73	2	1	hr. min.

9. Birthplace Dalton Ga (Town, county, and state)
10. Usual Occupation Telegraph Operator
11. Industry or business R R Co

FATHER — 12. Name John Smith
13. Birthplace Ga

MOTHER — 14. Maiden Name Frances Brooks
15. Birthplace Ga

16 (a) Informant Ida M Smith
(b) Address 327 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Fulton & Gore
(b) Address 1217 Harford Av

19 (a) FEB 1 1946 (Date rec'd by registrar) (b) Huntington Hills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946 at 7 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to Feb 2 1946. and that I last saw him alive on Feb 2 1946.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Cerebral Arterio Sclerosis	5 yrs
Due to Chronic Myocarditis	8 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North Av Date signed Feb 3-46 M. D.

VS 150

63706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

63706 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Warden St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Mark Dewberry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Julia Dacey Dewberry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1871

8. AGE: Years	Months	Days	If less than one day
75	0	0	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Mark Dewberry
13. Birthplace England

MOTHER
14. Maiden Name not obtainable
15. Birthplace England

16 (a) Informant Mr. Frederick L. Dewberry
(b) Address 4814 Coleherne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Measurson
(b) Address 805 North Calvert street

FEB 4 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 - 1946, at 4.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 1 1946 and that I last saw him alive on 2/1 1946.

Immediate cause of death	Duration
Hypertension Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wyland Talley M.D.
Address 5703 Hartford Rd. Date signed 2/3/46

X

63707 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 63707

CERTIFICATE OF DEATH 1190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 months

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Sudbrook Court.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

3 (a) **FULL NAME** Barry Edward Ladson ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1945

8. AGE: Years	Months	Days	If less than one day
	4	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack A. Ladson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth McGill
15. Birthplace Baltimore, Md.

16 (a) Informant Jack A. Ladson
(b) Address 2 Sudbrook Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Druid Hill
Location

18 (a) Funeral director Wm. J. Leckie & Son
(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Huntington for [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1946, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1946 to Feb. 1 1946 and that I last saw him alive on Feb 1 1946

Immediate cause of death	Duration
Acidosis	
Due to Diarrhea, Etiology Unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard A. Lapp, M.D.

Address Union Memorial Hospital Date signed Feb 4 1946

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63708 N.I BALTIMORE CITY HEALTH DEPARTMENT V 63708
CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution:
St. Agnes Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Fern Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/46

8. AGE: Years: 1 day. | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leslie G. Ryan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jean E. Sheain
15. Birthplace Pittsburg Pa.

16 (a) Informant Mr. G. A. Sheain
(b) Address 4403 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) FEB 4 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 19 46, at 12 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 19 46, to 2/3 19 46, and that I last saw h. alive on 2/3 19 46.

Immediate cause of death: Cardio-Resp. failure — Duration
Due to: Prematurity
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Chas. E. Carl M.D.
Address St. Agnes Hosp. Date signed 2/3/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G5709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Allendale Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Allendale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA B. LOWE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frank T. Lowe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert A. Barker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine J. Harbig
15. Birthplace Baltimore, Md

16 (a) Informant Mr. F. R. Behringer
(b) Address 612 Brookwood Ave.

17 (a) Burial (b) Date thereof 2/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 4 1946
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1946 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1941 to 2/1 1946 and that I last saw her alive on 2/1 1946

Immediate cause of death	Duration
Myocardial insufficiency	2 mo.
Due to Arteriosclerotic heart	4 yrs.
Due to Chronic	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reitz M. D.
Address 3408 Windsor Ave. Date signed 7/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G3700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Callaway Ave (If rural give location)
(e) Citizen of foreign country? not (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Buehler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Elsie Buehler

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1879

8. AGE: Years	Months	Days	If less than one day
66	1	15	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business The Hub

FATHER
12. Name Luther Buehler
13. Birthplace Penna

MOTHER
14. Maiden Name Ruth Metzger
15. Birthplace Penna

16 (a) Informant Mrs. Elsie L. Buehler
(b) Address 3500 Callaway Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Wm. J. Sligo & Sons
(b) Address Baltimore

19 (a) FEB 4 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at 1:14 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Feb 2 1946, and that I last saw h. / Malive on Feb 2 1946.

Immediate cause of death	Duration
Coronary Thrombosis	4 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Milton Linthicum M. D.
Address Mercy Hosp Date signed 2/2/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 637061

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 Elrino Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 5
(c) City or town 309 Elrino Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN L. GOFF

3 (b) If veteran, name war	3 (c) Social Security Account No.
W W # I	212-09-1487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Idella Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/26/1898

8. AGE: Years	Months	Days	If less than one day
47	3	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Stationary Fireman
11. Industry or business

FATHER
12. Name Paul Goff
13. Birthplace Va.

MOTHER
14. Maiden Name Lilly Routon
15. Birthplace Va.

16 (a) Informant Family
(b) Address 309 Elrino Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Md.

18 (a) Funeral director James L. McCully
(b) Address 130 E. Fort Ave.

19 (a) FEB 4 1946 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 11 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to Jan 31 1946, and that I last saw him alive on Jan 31 1946.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic Heart Disease	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E C Evans M. D.
Address Liberty Parkway Date signed 2-1-46

E. R. Evans

VS 150

G37002 ✓ G37002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 Druid Hill Ave.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William O. Cummings

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Janie Burgess,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Harry Cummings
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eliza Jane Davage
15. Birthplace Baltimore, Md.

16 (a) Informant Ida Cummings
(b) Address 1234 Druid Hill Ave.

17 (a) Burial (b) Date thereof Feb. 4, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1063 Druid Hill Ave.

19 (a) FEB 4 1946 (b) Langston Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31st 1946 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1946 to Jan 31 1946 and that I last saw h alive on Jan 31 1946

Immediate cause of death	Duration
Pancreatic Pneumonia	10 D
Due to Streptococcal Infection	
Due to Both Lungs	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. H. Magruder
Address 14 E Read St Date signed 2/7/46

VS 150

Vernon 2689

G37063 BALTIMORE CITY HEALTH DEPARTMENT ✓ 46 F Registered No. G37063

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights
(c) Hospital or institution: Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3/4
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Schwartz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

MEDICAL CERTIFICATION 45

20. DATE OF DEATH 2-4 1946, at 12 M

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Harry S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Max Lester
13. Birthplace Lith.

MOTHER 14. Maiden Name Henrietta
15. Birthplace Lith.

16 (a) Informant Mrs. L. G. Schwartz
(b) Address 1811 Munsey Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-46 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Belair Rd & Bowley Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 4 1946

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 19 to 2/2 19 46 and that I last saw h[illegible] alive on 2/2 19 46.

Immediate cause of death	Duration
Carcinoma of Liver	
Due to "	
Due to "	
Other Conditions "	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Hornstein M. D.
Address 733 Augusta St Date signed 2/4/46

Vs. 150

637064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

B 37064

Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 North Longwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 North Longwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD L. COHAN

3 (b) If veteran, name war 1914-

3 (c) Social Security Account No. 38-07-5993

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Fannie L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Providence R.I. (Town, county, and state)

10. Usual Occupation manager

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Sophie
15. Birthplace Russia

16 (a) Informant Fannie L Cohan
(b) Address 1900 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (month) (day) (year)
(c) Cemetery or crematory Balto Nat. Cem.
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place

19 (a) FEB 4 (Date rec'd by registrar) (b) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/46 19 , at 5:20 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive Cardiovascular Disease

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P. Davis M.D.
Medical Examiner.
Date signed 2/4/46

VS 151

930

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

G37065 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 784 W. Saratoga
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 784 W Saratoga
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Blank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1889

8. AGE: Years 56 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Charles Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William H. Dyson

13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Scott

15. Birthplace Md.

16 (a) Informant Mary M. Butler

(b) Address 784 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto. City

18 (a) Funeral director Samuel W. Sullivan Jr.

(b) Address 117 N. Carrollton Ave.

19 (a) FEB 4 1946 (Date rec'd by Registrar) (b) Huntington Wilson Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1946, at 8.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28-1946 to 2-2-1946, and that I last saw her alive on 2-2-1946.

Immediate cause of death	Duration
Chronic myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C R Campbell M. D.

Address 718 Dolphin St. Date signed 2-3-46

637066 ✓ 637066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. .....

HB #99264

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4240 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals ✓ O
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 67 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME George H. Smith ✓

3 (b) If veteran, name war	3 (c) Social Security Account No. 214-116-6083

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 27-1878

8. AGE: Years	Months	Days	If less than one day
67 ?	5	3 5	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business .....

FATHER
12. Name James Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Daniels
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5th 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location .....

18 (a) Funeral director Charles P. Powell
(b) Address 4927 Edmondson Ave.

19 (a) FEB 4 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1- 1946, at 9.55PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31- 1946, to 2-1- 1946, and that I last saw him alive on 2-1- 1946

Immediate cause of death	Duration
Lobar Pneumonia	?
Due to	.....
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature T. B. Gerrigan M. D.
Address Baltimore City Hosp. Date signed 2-2-46

VS 150

G37067 ✓ G37067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Classen Ave.
(c) Hospital or institution: 15 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Classen Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Fishpaw, (Fishpaugh)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow,

6 (b) Name of husband or wife: Wm. Thomas Fishpaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1876

8. AGE: Years 69 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife,

11. Industry or business at Home

FATHER
12. Name Andrew Jamison,
13. Birthplace Ireland

MOTHER
14. Maiden Name Whalen,
15. Birthplace Ireland, ?.

16 (a) Informant Nellie Williams,
(b) Address 2701 Classen Ave.,

17 (a) Burial (b) Date thereof 2/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jessups Cem.
Location Balto. Co. Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) FEB 1 1946 (b) Huntington Williams
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 1st. 1946 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Feb. 1 1946, and that I last saw her alive on Feb. 1 1946

Immediate cause of death: Cerebral hemorrhage — Duration 5 hrs

Due to: Hypertension — 4 yrs

Due to: Arterio Sclerosis — 4 yrs

Other Conditions: Myocarditis — 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. De Barber M. D.
Address 4723 Park Heights Date signed

VS 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3708 — BALTIMORE CITY HEALTH DEPARTMENT — G3708

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Frank Baum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1864

8. AGE: Years	Months	Days	If less than one day
82	0	24	hr. min.

9. Birthplace Baltimore Md. U.S.A. (Town, county, and state)
10. Usual Occupation Plasterer
11. Industry or business

FATHER
12. Name Valentine Baum
13. Birthplace Germany

MOTHER
14. Maiden Name Cunegunda Straub
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 917 Drummond Ave

FEB 4 1946 (Date rec'd by local registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946, to Feb 2 1946, and that I last saw him alive on Feb 2 1946.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Traill M. D.
Address 1631 E North Ave Date signed Feb 3-46

5:45 - X Feb 2, 1946

G37069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G37069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 S. Decker St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Freund

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife MRS. EMMA Freund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/80

8. AGE: Years	Months	Days	If less than one day
65	3	27 22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Charles Freund
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Cook
15. Birthplace Baltimore

16 (a) Informant Emma Freund
(b) Address 16 S. Decker St.

17 (a) Burial (b) Date thereof 2/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Oak Lawn
Location Eastern Ave. Road

18 (a) Funeral director John A. McGann
(b) Address 300 E. Baltimore St. Huntington Hotel

19 (a) (Signature) (b) Registrar
FEB 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1946, 1:43 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 28 1946 to Feb. 2 1946, and that I last saw h/xx alive on Feb. 2 1946.

	Duration
Immediate cause of death METASTASES from Carcinoma of Bile Duct, especially	?
Due to TO LIVER	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1/31/46
Major findings of operation: Carcinoma of Bile Duct with metastases to liver
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Oscar M. Camp M.D.
Address Church Home & Hosp. Date signed 2/4/46

OSCAR M. CAMP, M.D.

G.3.0.0 ✓ G.3.0.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 762 W. Mulberry St
(c) Hospital or institution:

17 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 762 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Brooks

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thomas Brooks
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 1892

8. AGE: Years 53 | Months 11 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Calvert Co. Md
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business own home

FATHER
12. Name Richard Cross
13. Birthplace md

MOTHER
14. Maiden Name Mary Jones
15. Birthplace md

16 (a) Informant Thomas Brooks
(b) Address 762 Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-46 (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Mutual, Calvert Co., Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2-1946, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15-1945 to 2-2-1946 and that I last saw h[illegible] alive on 2-1-1946.

Immediate cause of death	Duration
Cerebral hemorrhage	3 days
Due to Hypertension and arterio Sclerosis	unknown
Due to	
Other Conditions Diabetes mellitus	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 2-2-46

FEB 4 1946 Walter Williams Registrar

VS 10a

83 a

G3,071 ✓ G3,071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 21B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2242 Penna Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2242 Penna Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarena E. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Male | 5 Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Vera Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1894

8. AGE: Years 51 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name John Jones
13. Birthplace Calvert Co Md

MOTHER 14. Maiden Name Mary Culley
15. Birthplace Calvert Co Md

16 (a) Informant Vera Jones
(b) Address 1639 Booker Ct

17 (a) Burial (b) Date thereof 2/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. E. Nelson
(b) Address 1303 Pressstman St

19 (a) (b)
(Date rec'd by registrar) (Registrar)

FEB 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946 (hour) 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1945 to 1/31 1946, and that I last saw him alive on January 30 1946

Immediate cause of death Pulmonary Edema — Duration ~
Due to Sarcoidosis — Duration over
Due to — Duration
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Howell M. D.
Address 1601 N Carrollton Ave Date signed 2/4/46

G3,0,2 ✓ G3,0,2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N. Carey Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Milton B. Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Mildred Reed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-1899

8. AGE: Years	Months	Days	If less than one day
46	3	17 16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Andrew J. Reed
13. Birthplace md.

MOTHER
14. Maiden Name Annie C. Reed
15. Birthplace md.

16 (a) Informant Mildred Reed
(b) Address 1316 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-46 (month) (day) (year)
(c) Cemetery or crematory Mt Cabvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) (Date rec'd by registrar) (b) Evelyn Williams, M.D. Registrar

FB 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 1946, at 2.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1945 to 2-1 1946 and that I last saw h[illegible] alive on 2-1 1946

Immediate cause of death	Duration
Azotemia, Conjestive Heart failure	
Due to Hypertensive Cardio-vascular-renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D. Harris M. D.
Address [illegible] Date signed 2/1/46

63073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700 63073 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth ~~Brafford~~ President

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29-1941 ~~194~~

8. AGE: Years	Months	Days	If less than one day
4	3	3	hr. min.

9. Birthplace Waynesboro Ga. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Edgar President
13. Birthplace Ga.

MOTHER
14. Maiden Name Carrie Bell Koger
15. Birthplace Ga.

16 (a) Informant Edgar President
(b) Address 1633 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-46 (month) (day) (year)
(c) Cemetery or crematory
Location Waynesboro, Ga.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Edmondson Ave.

19 (a) [illegible] (Date rec'd by registrar) (b) for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2nd 1946 at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/2/46 at 6/5 2 P. M.
(b) Where did injury occur? Fayette & Broadst
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by truck

23. Signature Robert E. Fraham M.D. Medical Examiner.
Date signed 2-3-46

(over)

G37074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186a

G37074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles H. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1872

8. AGE: Years 73 | Months 9 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Co.
(Town, county, and state)

10. Usual Occupation Retired Steamfitter

11. Industry or business

FATHER
12. Name Chas H. Jones
13. Birthplace Balto Co

MOTHER
14. Maiden Name Cyrilla M Smithers
15. Birthplace Anne Arundel Co

16 (a) Informant Dr Badger
(b) Address 1111 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7 46 (month) (day) (year)

(c) Cemetery or crematory Mt Gilead
Location Balto Co

18 (a) Funeral director J F Ellen Sons
(b) Address Reisterstown Md

19 (a) FEB 4 1946 (Date rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1946, at 9:05 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Arteriosclerosis, marked; Coronary Thrombosis; Old in fanction 2 Heart; Subdural Hematomas 2

Other conditions Brain, traumatic

(Include pregnancy within 3 months of death)

22. If an external cause was contributing to cause of death, fill in the following:
(a) Date of injury 10-30-45 18/2
(b) Where did injury occur? Found lying on steps at 1111 Edmondson Ave
(c) Did injury occur at home, on farm, industrial place, in public place? HOME While at work? NO
(d) Means of injury Probable fall

23. Signature Robert L. Gretzer M.D.
Medical Examiner.
Date signed Feb 4 1946

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37075

BALTIMORE CITY HEALTH DEPARTMENT X 6

CERTIFICATE OF DEATH

G37075 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town La Platta
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Susie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Married

6 (b) Name of husband or wife John Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69 ~~49~~?			hr. min.

9. Birthplace Chas. Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory
Location La Plata Md.

18 (a) Funeral director Hunt & Ryon
(b) Address Waldorf, Md.

19 (a) FEB 1 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1946 at 10 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1946 to 2-3 1946 and that I last saw her alive on 2-3 1946

Immediate cause of death Meningococcic meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. K. Hunt M. D.

Address Waldorf Date signed 2-4-46

x Balto md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32076 / 1226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Jolie Sts.
(c) Hospital or institution: Hosp. for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Powhattan Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** SARA COLGATE WAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/1960 70

8. AGE: Years	Months	Days	If less than one day
75	11	7	hr. min.

9. Birthplace PATAPSCO NECK BALTO CO., MD.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name LEWIS E. WAY
13. Birthplace MARYLAND (Balto. Co.)

MOTHER
14. Maiden Name SARAH GRAVES
15. Birthplace MARYLAND (Balto Co.)

16 (a) Informant HELEN WAY
(b) Address 3107 BELVEDERE RD.

17 (a) Burial (b) Date thereof 2/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 4 1946 (b) [illegible]
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 3 1946, at 2:31 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 2 1946, to FEB. 3 1946, and that I last saw her alive on FEB. 3 1946.

Immediate cause of death	Duration
Intestinal OBSTRUCTION, ACUTE (Small intestine)	3 days
Due to Adhesions, Post-operative.	
Due to	years
Other Conditions ~~Tumor of head of pancreas (Cystic Duct)~~ (Include pregnancy within 3 months of death)	over

Date of operation ~~Feb. 2, 1946~~
Major findings of operation:
of autopsy: Marked gastric, duod. & jejunal dilatation;

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Richard Crayston M.D.
Address Hospital for Women Date signed 4 Feb 46

G37077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 E. Biddle St.
(c) Hospital or institution:

q 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche E. Steinert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Frank A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1869

8. AGE: Years	Months	Days	If less than one day
76	5	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name George C. Rose
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Nelson
15. Birthplace Baltimore

16 (a) Informant Frank A. Steinert
(b) Address 2324 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date received by registrar) FEB 4 1946 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan 1946, and that I last saw her alive on Jan 1946

Immediate cause of death	Duration
Hypo Stat Pneumo	1/25th
Due to	
Ch. Myocard. d.s	1940
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Ryland M.D.
Address 801 N. Kenwood Ave Date signed 2/2/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37078 / 14

Registered No. G37078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hubert Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1942

8. AGE: Years	Months	Days	If less than one day
3	4	-	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Daniel Gray

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Leah Marshall

15. Birthplace Greenwood, S. C.

16 (a) Informant Mrs. Leah M. Gray

(b) Address 1701 N. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) FEB 4 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1946 to Feb 2 1946 and that I last saw him alive on Feb 2 1946

	Duration
Immediate cause of death Resp. failure	
Due to Tuberculous Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature K. O. Hoover, M.D.

Address Univ Hosp. Date signed 2/4/46

G37079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G37079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1333 Fulton Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1333 Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Mae Whidbee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William S. Whidbee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1878

8. AGE: Years 67 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Hertford N.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Hawkins
13. Birthplace N.C.

MOTHER
14. Maiden Name Hester Perry
15. Birthplace N.C.

16 (a) Informant Eliza Gibson
(b) Address 1333 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Miss Kate R. Williams
(b) Address 3229 N. Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1945 to 1/31 1946, and that I last saw h alive on 1/31 1946

Immediate cause of death (a) Uremia
Myocarditis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Wm. Sprigg Lemmon M. D.
Address 1111 Eutaw Pl Date signed 2/4/46

VS 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37080 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 Ridgely St.
(c) ~~Hospital~~ or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore-30-MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Ridgely.ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William J.Leonard, JR

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28/1891

8. AGE: Years	Months	Days	If less than one day
55	NO	4	hr. min.

9. Birthplace Baltimore, MD.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Glass Co

FATHER
12. Name William J.Leonard, SR.
13. Birthplace Virginia

MOTHER
14. Maiden Name Ellen Sheridan
15. Birthplace New York City

16 (a) Informant Margaret M.Shiloh
(b) Address 1118 Ridgely, ST.

17 (a) Burial (b) Date thereof Feb 5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Catherdral
Location Old Frederick RD

18 (a) Funeral director Ambrose, INC.
(b) Address 414 N. Franklintown, RD,

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 4 1946 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1946 at 6 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from December 15 1945 to Feb. 1 1946, and that I last saw him alive on Jan. 31 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris H. Steinberg M.D.
Address 410 N. Hilton St Date signed 4 Feb 46

D. No. 635082 G37081

733 Arlington Ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1577M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2804 Southern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Lee Morgan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21 1944

8. AGE: Years	Months	Days	If less than one day
1	9	13	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Henry L. Morgan
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Garrity
15. Birthplace Md

16 (a) Informant Mr Henry L. Morgan
(b) Address 2804 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. J. Ruck
(b) Address 5205 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar Williams

Buried FEB 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1946 to 2/3 1946 and that I last saw her alive on 2/2 1946

Immediate cause of death: Congenital Tumor of dorsal spine

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Thomasteen M. D.

Address 733 Arlington Ave Date signed 2/4/46

X

G37082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G37082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Kildaire Drive (If rural give location)
(e) Citizen of foreign country? Not. (Yes or No) If yes, name country

3 (a) FULL NAME Michael G Bruder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13-1927

8. AGE: Years	Months	Days	If less than one day
19	—	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Michael A Bruder
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth R. Martin
15. Birthplace Md

16 (a) Informant Mrs Elizabeth R. Bruder
(b) Address 2703 Kildaire Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director [illegible]
(b) Address 5345 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1946, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1945 to 2/2 1946, and that I last saw h[illegible] alive on 2/2 1946

Immediate cause of death Complications respiratory failure — Duration

Due to Cachexia + malnutrition

Due to Generalized Carcinomatosis from Carcinoma of ileum

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene J Riley M. D.
Address 1400 N Charles St Date signed 2/2/46

FEB 4 1946

VS 150

G37083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G37083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Port St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Wieniewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Ignatius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Franciszk Posviatowski
13. Birthplace Poland

MOTHER
14. Maiden Name Eva Miedzwiecka
15. Birthplace Poland

16 (a) Informant Ignatius Wieniewski
(b) Address 1213 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2809 Hudson St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 8 1946 Hunting Town Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1946, at 5:28 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1945 to Feb. 2 1946, and that I last saw her alive on Feb. 2 1946.

	Duration
Immediate cause of death Uremia	2 wks.
Due to Renal arteriosclerosis	4 yrs.
Due to Generalized Senile Type Arteriosclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeBoeuf M. D.
Address 601 S. Ellwood Ave. Date signed 2-3-46

G37084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37084 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 S East Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 S East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M Barron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida C Barron
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Mar 15-1869

8. AGE: Years 76 | Months 10 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Stationary Engineer
11. Industry or business Retired.

FATHER
12. Name John Barron
13. Birthplace Maryland

MOTHER
14. Maiden Name Dont Know
15. Birthplace Ireland

16 (a) Informant Ida C Barron
(b) Address 233 S East Ave

17 (a) Burial (b) Date thereof Feby 6th
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pasadena Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 210 E Orleans St

19 (a) 1946 Huntington Hillman
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 2 1946, at 1.20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 1 1945 to Feb 2 1946, and that I last saw h[illegible] alive on Feb 2 1946.

Immediate cause of death: Uremia — Duration: 1 day

Due to Chronic Myocarditis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Judd
Address 3373 E. Baltimore St Date signed 2/3/46

VS 150

G37085 N.I

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G37085

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore-Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 Avon Beach Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		a	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 4 1946 (b) Huntington Williams, Jr. M.D.
(Date rec'd by registrar) Registrar

FEB 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946, at 6:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to Tear of Tentorium cerebelli

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gruber M.D.
Medical Examiner.
Date signed 1-29-46

VS 151

3275

correct age is especially important. Physicians: please write the c

~~37086~~ ~~37086~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dth
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Pearl St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Duncan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) M1

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 4 1946 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 January 1946, at 10:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Stafford M.D. (Medical Examiner)
Date signed 21 January 46

3576

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37087 N.I

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32087

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division st.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 W. Fenton st.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Joynes

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-46

8. AGE: Years	Months	Days	If less than one day
			10 hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Claude Laurence
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lucille Joynes
15. Birthplace Balto. Md.

16 (a) Informant Lucille Joynes
(b) Address 310 W. Fenton St.

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 2/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director A. Hablett
(b) Address 911 E. Dru[illegible] Hunt
19 (a) [illegible] (Write word for registrar) (b) Huntington Williams Registrar

FEB. 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29- 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29-1946, to 12 M 1-29-1946, and that I last saw h[illegible] alive on 1-29-1946.

Immediate cause of death	Duration
Prematurity	6 hrs.
Due to Maternal toxemia of pregnancy	
Due to Infection & toxemia of Mother	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Lorain Young M. D.
Address 1100 Linden Ave Date signed 2/3/46

X

GB7088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G37088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 758 Melville Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louisa Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Edward Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 27 - 1869

8. AGE: Years 76 | Months 3 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Smith Kelly
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Louella Elliott
15. Birthplace: Maryland

16 (a) Informant: George E Mitchell
(b) Address: 758 Melville Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical Sch

18 (a) Funeral director: Commissioner of Health
(b) Address

FEB 4 1946
(Date rec'd by registrar)

FEB 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 31 - 1946, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1946, to Jan 31 1946 and that I last saw her alive on Jan - 31 - 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Arteriosclerosis Cardiovascular Dis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: George F McNamara M. D.
Address Date signed 1/31/46

VS 150

F3277

107

G37089

G37089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 Highfield Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Highfield Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Herman Deute

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Florence Grebe

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 1/12/1891

8. AGE: Years 55 | Months ✓ | Days 21 | If less than one day hr. min.

9. Birthplace Oregon City, Oregon
(Town, county, and state)

10. Usual Occupation President

11. Industry or business National Brewing Co.

FATHER
12. Name Otto Deute
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Oregon

16 (a) Informant Mrs. Florence G. Deute
(b) Address 203 Highfield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1600 Eutaw Place

19 (a) (Date rec'd by registrar) Registrar

FEB 4

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at 11 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1945, to Feb 2 1946, and that I last saw him alive on Feb 1 1946.

Immediate cause of death	Duration.
Coronary thrombosis	1 day
Due to Coronary artery disease + thrombosis	3 mos
Due to Hypertension + diabetes	2 yrs
Other Conditions Amputation of left leg due to thromboplastic	

(Include pregnancy within 3 months of death)

Date of operation Oct 25-45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lantz M.D.

Address Temple Garden apts Date signed 2/3/46

X

G37090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

~~G37090~~

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Bishop Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William P. Gundry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Isabelle Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1874

8. AGE: Years 71 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Athens, Ohio
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name Richard Gundry
13. Birthplace London, England

MOTHER
14. Maiden Name Mary Martha Kitz-Harris
15. Birthplace Dublin, Ireland

16 (a) Informant Dr. Alfred T. Gundry
(b) Address 5002 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemy.
Location Frd. Ave., Balto., Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) 1940 (Date rec'd by registrar) (b) Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/1946 to 2/3/1946 and that I last saw h[illegible] alive on 2/3/1946.

Immediate cause of death: Congestive Heart Failure — Duration: 24 hr.

Due to: Myocardial Weakness

Due to: Pernicious Anemia & Chr. Bronchitis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 2/3/46

G37091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37091 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 west 40th St.
(c) Hospital or institution:
Home for Incurables. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 West 40th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If so, name country

3 (a) FULL NAME Mrs. Belle M. Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Robert Anderson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1876

8. AGE: Years	Months	Days	If less than one day
69	9	21	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name George Washington Mitchell
13. Birthplace Virginia

MOTHER
14. Maiden Name Anna Beasley
15. Birthplace Virginia

16 (a) Informant Brooks Home for Incurables
(b) Address 700 west 40th st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John B. Mitchell & Son
(b) Address 1900 Eutaw Pl.

19 (a) (Date rec'd by registrar) (b) Registrar

VS # FEB 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 3 1946, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1945 to Feb. 3rd 1946, and that I last saw h[illegible] alive on Feb. 3rd 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	3 hours
Due to Hypertension Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Weyl
Address 11 E. Chase St. Date signed 2/4/46
Baltimore 2 Md. X

G37092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G37092 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1143 Ward St.,
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 Ward St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John R. Scheppske or (Schepsky)

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-07-5420

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lucy Scheppske

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1907

8. AGE: Years 38 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Balto. City

FATHER
12. Name John Scheppske
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katie Schriver
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John Scheppske
(b) Address 1143 Ward St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

FEB 4 1946 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1946, at 8.55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to Feb 1 1946, and that I last saw him alive on Feb 1 1946

Immediate cause of death Carcinoma, malignant of pharynx — Duration 3 yrs.

Due to

Due to

Other Conditions Hemorrhage Left Mandible Malnutrition — 21 Jan 46

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Ulrich, Jr

Address 1242 Wash. Blvd. Date signed Feb 4 46

Huntington Williams, M.D.

X

G37093

BALTIMORE CITY HEALTH DEPARTMENT

~~Standard Certificate~~ CERTIFICATE OF DEATH 46H

Registered No. G37093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Puget St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Brock.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-1893

8. AGE: Years 52 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name January Gibson
13. Birthplace S. C.

MOTHER
14. Maiden Name? Adrena Bethune
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial-Removal (b) Date thereof 2-6-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sumter, S. C.
Location Sumter, S. C.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (a) Filed by registrar 1946 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1946 at 8.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Feb 1, 1946, and that I last saw h.. alive on Feb 1, 1946.

Immediate cause of death: Congestive heart failure
Uremia — Duration

Due to: Carcinomatosis peritonei

Due to: Granulosa cell tumor, ovarian bilateral

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Nolan M. D.

Address 609 N Broadway Date signed 2-1-46

DIRECTIONS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G37094
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2762 Kinsey Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2762 Kinsey Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Santmyer~~ Mark K. Santmyer

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-6643

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sadie E. Santmyer
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 18, 1873

8. AGE: Years	Months	Days	If less than one day
72	7	14	hr. min.

9. Birthplace Oakland, Garrett Co., Md.
(Town, county, and state)
10. Usual Occupation Electrical Operator
11. Industry or business B & O RR

FATHER
12. Name George Santmyer
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Mae
15. Birthplace Maryland

16 (a) Informant Mrs. R. Willett
(b) Address 4303 Kathland Ave.

17 (a) Burial (b) Date thereof Feb. 5, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Charles L. Donovan
(b) Address 4510 Liberty Heights Ave.

19 (a) (b) Waiting for Military Affair
(Date certificate received by registrar)

FEB 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Feb 1946, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 5th 1946, to Feb 2 1946, and that I last saw him alive on Feb 1st 1946.

Immediate cause of death	Duration
Hypostatic Pneumonia	3 days
Due to Chronic Myocarditis with decompensation	years
Due to Coronary disease, Chronic with Angina pectoris	2-3 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence L. Brown M.D.
Address 1938 Linden Ave. Date signed 3rd Feb 46

G37095 G37095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Whiteford - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Campbell Whiteford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Nora L Whiteford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec - 23 - 1880

8. AGE: Years	Months	Days	If less than one day
65	1	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer - Canner
11. Industry or business

FATHER
12. Name W. Scott Whiteford
13. Birthplace Maryland

MOTHER
14. Maiden Name Marcia McCarthy
15. Birthplace Penn

16 (a) Informant Nora L Whiteford
(b) Address Whiteford - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/46 (month) (day) (year)
(c) Cemetery or crematory Stateville Pa
Location York County
18 (a) Funeral director Hubert P. Matthews
(b) Address Delta, Penna.
19 (a) Filed by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 4 - 1946, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to Feb - 4 - 1946 and that I last saw h/ alive on Feb - 4 - 1946

Immediate cause of death Uremia
Acute Bronchitis
Hypertension Heart Dis

Duration

Due to
Due to
Other Conditions Arteriosclerosis Heart Dis
(Include pregnancy within 3 months of death)

Date of operation Jan - 31 - 46
Major findings of operation:
Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A Schlaudecker M.D.
Address Date signed 2/6/46

VS 150

X Geo. A. Schlaudecker

637096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 637096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4810 Frederick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4810 Frederick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Wolle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14. 1877

8. AGE: Years 68 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Wolle
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Strauss
15. Birthplace Germany

16 (a) Informant Mrs. Anna R. Wolle
(b) Address 4810 Frederick Ave

17 (a) Burial (b) Date thereof Feb. 5 '46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Little
(b) Address 4101 Edmondson Ave

19 (a) Filed (Date rec'd by registrar) FEB 5 1946 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1946, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Feb 2 1946 and that I last saw h l alive on Jan 19 1946.

Immediate cause of death	Duration
(a) Coronary Thrombosis	15 min
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature J. M. Collins M. D.
Address 3321 Frederick Date signed 2/4/46

VS 150

X

G37097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G37097

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 E. Preston
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David C. Price

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Keziah Tracy Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31st 1855

8. AGE: Years 90 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace Egypt Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Blacksmith

FATHER
12. Name Robert Price
13. Birthplace Md.

MOTHER
14. Maiden Name Adaline Parks
15. Birthplace Md.

16 (a) Informant Clement T. Bussey
(b) Address 5008 Walther Blvd

17 (a) Burial (b) Date thereof 2/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jessups
Location Cockeysville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) FEB 5 1946 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3rd 1946, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Feb 3 1946 and that I last saw h/ Hm alive on 2/3 1946

Immediate cause of death	Duration
Arteriosclerotic Cardio-Renular Renal Disease	?
Due to	
Due to	
Other Conditions Uremia	1 week

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm S. Bloom M.D.
Address 706 E. Belvedere Date signed 2/5/46

VS 150

637098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered 637098

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Harwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Harwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guy A. Owens

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1882

8. AGE: Years	Months	Days	If less than one day
63	1	13	hr. min.

9. Birthplace Westminster Md
(Town, county, and state)
10. Usual Occupation Painter + Plumber
11. Industry or business Mercantile Trading Co

FATHER
12. Name Horace R. Owens
13. Birthplace Carroll Md

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant John C Boyden
(b) Address 608 Harwood Ave

17 (a) Burial (b) Date thereof 2/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a). Funeral director Pulliam + Boyden
(b) Address 1217 E Fayette St

19 (a) FEB 5 1946 Interring for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945, to Feb 3 1946 and that I last saw h. alive on Feb 2 1946.

Immediate cause of death	Duration
(a) Carcinoma R. Lung.	3 Mo
Due to	
Due to	
Other Conditions Amputation R. Leg. Arteriosclerosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 2020 E. Clark St Date signed 2/4/46 M. D.

G37099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered No. G37099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Herlein

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female **5. Color or race** White **6 (a) Single, married, widowed, or divorced** Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 31868

8. AGE: Years 77 Months 5 Days 21 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Herlein
13. Birthplace Bavaria, Germany

MOTHER
14. Maiden Name Katharine Lonal
15. Birthplace Bavaria Germany

16 (a) Informant Merony Coles
(b) Address 3211 Rogers Ave

17 (a) Burial **(b) Date thereof** 2/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director Wilson Bros Co
(b) Address 1217 E Fayette St

19 (a) FEB 5 1946 **(b)** Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1946, at 12 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Jan 3 1946 and that I last saw him alive on Jan 3 1946.

Immediate cause of death Carcinoma of Rectum — **Duration** 2 Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Graham G Davies M. D.
Address 800 W 39th St **Date signed** 2-4-46

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G37100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G37100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JOSEPH ZIERS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Mary E. Ziers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1855

8. AGE: Years	Months	Days	If less than one day
91	0	28	hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual Occupation Teamster
11. Industry or business

FATHER
12. Name Peter Ziers
13. Birthplace Germany

MOTHER
14. Maiden Name Bridgit ?
15. Birthplace England

16 (a) Informant Mr. Howard J. Ziers
(b) Address 3613 Hillsdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1946, at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 19 1945 to Feb. 3 1946 and that I last saw h[illegible] alive on Feb. 1 1946

Immediate cause of death	Duration
Hypostatic Acute Dilatation of Heart	
Due to	
Due to General Arteriosclerosis	✓
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature John A. Tudor M.D.
Address 1219 Cathedral St. Balto. Md. Date signed 2/4/46

VS 150
FEB 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G37101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 Cator Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Cator Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FERDINAND OTTE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1883

8. AGE: Years	Months	Days	If less than one day
62	9	0	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Carpenter Foreman (Rtd)
11. Industry or business City of Baltimore

FATHER
12. Name Ferdinand Otte
13. Birthplace Hanover, Germany

MOTHER
14. Maiden Name Wilhelmina Kaiser
15. Birthplace Germany

16 (a) Informant Mrs. Elmer Relleker
(b) Address 808 Cator Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 5 1946

VS 450

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 2, 1946, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/ 1945 to 2/2/ 1946, and that I last saw h im alive on 2/2/ 1946.

Immediate cause of death	Duration
Chronic cirrhosis of the liver.	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Relleker M. D.
Address 1226 Hanover St. Date signed 2/4/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45R

G37102 ✓ G37102 Registered No.

G37102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 63 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 W 33rd St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Clifton Roe

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Charles C. Roe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1882

8. AGE: Years 63 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Steam Fitter

11. Industry or business

FATHER 12. Name Thomas B Roe

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden Name Ella young

MOTHER 15. Birthplace Maryland.

16 (a) Informant Mrs. Elsie E. Roe

(b) Address 602 W. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b) Huntington Hills Registrar
(Date rec'd by registrar)

VS 150

FEB 5 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1946, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1945 to Feb 3 1946 and that I last saw h alive on Feb 3 1946

Immediate cause of death Squamous cell carcinoma of lower lip c Metastasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gayle B Arnold M.D.

Address Date signed 2-3-46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946

G37103 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 E. Baltimore Stree
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH ANNA HORST

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1869

8. AGE: Years 73 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Horst
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Butschky
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John Horst
(b) Address Chestnut Ave., Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 FEB 5 1946 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1946, at 11.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Feb 3 1946 and that I last saw h[illegible] alive on Feb 1946

Immediate cause of death Coronary Thrombosis — Duration 1 Hr

Due to Arteriosclerosis — yrs

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas F Black M. D.
Address 20 E Preston Balt Date signed 2/4/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37104

486841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56B

Registered No. G37104

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. Strieker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Edna Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: James Addison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Janitress

11. Industry or business

FATHER 12. Name Sammy Wills

13. Birthplace Md.

MOTHER 14. Maiden Name Cecelia Contee

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-5-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cemetery

Location Baltimore Maryland

18 (a) Funeral director Archibald P. Gaddis

(b) Address 2161 N. Gilmor St.

19 (a) FEB 5 1946 (b) Signature for Wilson

(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1946 at 5.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1946 to Feb. 2 1946 and that I last saw him alive on Feb. 2 1946.

Immediate cause of death: Massive pulmonary embolus

Duration

Due to Pelvic phlebothrombosis

Due to Post operative

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-19-46

Major findings of operation: Myoma uteri

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan

Address 1619 N. Broadway Date signed 2-2-46 M. D.

X

G37105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G37105 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - #12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Nicall Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Monroe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Not Known
Harry Monroe 66 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/1875

8. AGE: Years 70 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Conrad Shaefer
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Geise
15. Birthplace Maryland

16 (a) Informant Stratford Records
(b) Address Mercy Stratford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave

18 (a) Funeral director D. J. Faherty Sons
(b) Address 313 Light St.

19 (c) FEB 5 1946 (Date received by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2-46 19 , at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29-46 19 , to 2-2 19 46 and that I last saw her alive on 2-2 19 46.

Immediate cause of death	Duration
Cardio-Respiratory failure	2
Due to Ca of Stomach	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. A. Stadem Jr. M. D.
Address Mercy Hosp Date signed 2/2/46

VS 150

G37106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G37106 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 661 George St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maggie Dingle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard Dingle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-1905

8. AGE: Years 40 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Orangeburg S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Hamond
13. Birthplace S.C

MOTHER
14. Maiden Name Anna Hamond
15. Birthplace S. C.

16 (a) Informant Richard Dingle (Hus)
(b) Address 661 George St

17 (a) Burial (b) Date thereof 2-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto Md.

18 (a) Funeral director Chas. H. Corpew
(b) Address 512 Carrollton Ave.

19 (a) (b) Registered
(Date rec'd by registrar)

FEB 5 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 1946 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1946, to 2-1 1946, and that I last saw he alive on 2-1-1946.

Immediate cause of death	Duration
Lobar pneumonia, (bilateral)	3 days (history)
Due to	
Due to	
Other Conditions Hypertensive cardio vascular-Renal disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geary Lyle Donald M. D.
Address 844 Cary Date signed 2-1-46

637107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 637107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts
(c) Hospital or institution Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 Cherrydell Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Hartman Steudle (HARTMAN C. STEUDL)

3 (b) If veteran, name war None

3 (c) Social Security Account No. 715-17-1069

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E. Steudle

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Feb 14-1907

8. AGE: Years 38 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Paint Co

FATHER
12. Name Charles Steudle
13. Birthplace Germany

MOTHER
14. Maiden Name Otillia Jackson
15. Birthplace Md

16 (a) Informant Mary E. Steudle
(b) Address 132 Cherrydell Rd

17 (a) Burial (b) Date thereof Feb 6-1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balt Co B.M. Walters City

18 (a) Funeral director Potter & Streker Sts
(b) Address

FEB 5 1946 (Date rec'd by registrar) (b) Funeral for Willis Hartman

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/1946, at 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19/1946 to 2/3/1946 and that I last saw him alive on 2/3/1946.

	Duration
Immediate cause of death: Uremia	2 wks
Due to: Lymphoid Leukemia	1 yr.
Due to:	
Other Conditions: Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: Enlarged Liver, Spleen, Nodes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Smith Jr. M. D.

Address Bon Secours Hosp Date signed 2/3/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G37108 BALTIMORE CITY HEALTH DEPARTMENT G37108

CERTIFICATE OF DEATH 131 C

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1945 Booth St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 Booth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Lee (Murray)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race C
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife William Lee
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 1901
8. AGE: Years 44 Months 7 Days If less than one day hr. min.
9. Birthplace Malta (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Benjamin Murray
13. Birthplace Malta

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant William Lee
(b) Address 1945 Booth St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 '46. (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
19 (a) FEB 5 1946 (Date received by registrar) (b) [illegible] Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2-1946, at 5 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-2-1946, to 2-2-1946, and that I last saw her alive on 2-1-1946.

Immediate cause of death	Duration
Chronic Cardiorenal Disease	8 mos
Due to Senile Coma	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Signed 2/9/46

G37109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 Q

Registered No. G37109

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 W Lexington St
(c) Hospital or institution: 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 W Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Benjamin Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/27/72

8. AGE: Years 73 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Malta Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Tom Harris
13. Birthplace Malta Md

MOTHER
14. Maiden Name Mary Jane
15. Birthplace Malta Md.

16 (a) Informant Benjamin Cooper
(b) Address 1736 W Lexington St

17 (a) Burial (b) Date thereof Feb 5 '46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 (a) FEB 5 (b) 1946 Geo. Wm. Hill
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31 1946, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1945 to 1-31 1946, and that I last saw h[illegible] alive on 1-31 1946.

Immediate cause of death Uremia Cardio-vascular Renal disease — Duration 7 days 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1736 W Lexington Date signed 2/4/46

VS 150

G37110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G37110 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write plainly, with UNFADING INK. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Harford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Harford Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ## Sarah E. Yeakle

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Louis A. Yeakle
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) Oct. 9th, 1946

8. AGE: Years	Months	Days	If less than one day
81	3	25	#### hr. 864 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry T. Kline
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mulligan
15. Birthplace Unknown

16 (a) Informant Mrs. Mary A. Becker
(b) Address 1620 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 FEB 5 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/46 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to 2/3 1946 and that I last saw h[er] alive on Feb 2 1946

Immediate cause of death: Generalized Arteriosclerosis — Duration: 3 days
Due to Coronary Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evl Smith
Address 1223 E. North Ave
M. D.
Date signed 2/4/46

X

G37111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

Registered No. G37111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 1. 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 E. Chase
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph H. Stresewski

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 214-14-2041

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 1 1891

8. AGE: Years 54 | Months 8 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name Antone Stresewski
13. Birthplace Germany

MOTHER
14. Maiden Name Helomena Feldsman
15. Birthplace Germany

16 (a) Informant Edward Stresewski
(b) Address 2025 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Frederick Road

18 (a) Funeral director George J. Ruth Inc
(b) Address 1735 Hayford Ave

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

FEB 6 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1946, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Tamponade,
Ruptured Aneurysm of Aorta

Due to Syphilitic Aortitis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grutzen M.D.
Medical Examiner.
Date signed 2-4-46

G37112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1671

G37112 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Woodall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Woodall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W Melnick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4 - 1935

8. AGE: Years 10 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John Melnick
13. Birthplace Germany

MOTHER 14. Maiden Name Sophie Serpenka
15. Birthplace Germany

16 (a) Informant Sophie Melnick
(b) Address 1422 Woodall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 16 - 46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn

18 (a) Funeral director John C Melly Inc
(b) Address 2435 Eastern Ave

19 (a) FEB 5 1946 (Date rec'd by registrar) (b) Huntington Wilson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 2 1946, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 4 1935 to 2 - 2 1946, and that I last saw him alive on 2 - 2 1946.

Immediate cause of death Congenital Hydrocephalus — Duration since birth 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Holland M. D.
Address 707 Fort Ave Date signed 2-4-46

X

G37113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 11 Reg. G37113

Type or print plainly in ink. Fill all items. If unknown, write unknown. If not applicable, write N.A. Be sure the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clay Thomas O'Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Hunter
(b) Address 121 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7th 1946 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Road

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patt. Park Ave

19 (a) (Date recd by registrar) FEB 5 1946 (b) Huntington & Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1946, at 11:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxia due to
Inhaling gas
Due to
Other Conditions Depression
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/30/46 accurate M.
(b) Where did injury occur? 1706 Hollins St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Inhaling gas from 3 burners

23. Signature [illegible] M.D. Medical Examiner.
Date signed 2/3/46

(over)

G37114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G37114 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 869 N. Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 869 N. Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Louis Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	4		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Earl Schrisky
(b) Address 4321 Mary Ave

17 (a) Burial (b) Date thereof 1-5th 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Morelands
Location Taylor Ave

18 (a) Funeral director Leo S. Leach
(b) Address 1901-03 N. Pratt Park Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 1946 at 1 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Lim death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Influenzal pneumonia

Due to

Other Conditions Acute cor pulmonale

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2-5-46

VS 151

FEB 1946

Physicians: please write the causes of death clearly and legibly. Be correct and especially important. Use necessary supplies. Be

G37115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

Registered No. G37115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 9 0
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Vincent St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Susie Jackson
3 (b) If veteran, name war —
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) 2/9/1903
8. AGE: Years 42 | Months 11 | Days 25 | If less than one day ..... hr. ..... min.
9. Birthplace A. A. Co Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Noah Queen
13. Birthplace Md

MOTHER
14. Maiden Name Hester Carroll
15. Birthplace Md

16 (a) Informant Ethel Jackson
(b) Address 722 N Vincent St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/36 (month) (day) (year)
(c) Cemetery or crematory Gibbons
Location Md
18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Presstman St
19 (a) Date rec'd by reg. 2-7-36 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th 1936 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Cardiac failure. Pulmonary edema

Due to Rheumatic endocarditis

Other Conditions Hypertensive cardio-vascular disease.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed 2-4-36

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. The age is especially important.

G37116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. G37116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 W. 27th street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 537 W. 27th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME PETER C. DOYLE

3 (b) If veteran, name war ----
3 (c) Social Security Account No. -----

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Louise C. Doyle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 9, 1880
8. AGE: Years 65 | Months 1 | Days 24 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Bridge Dept.
11. Industry or business Baltimore City

FATHER
12. Name Peter Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Kiernan
15. Birthplace Ireland

16 (a) Informant Miss Emily Doyle
(b) Address 2906 Grindon avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Ulf Frederick Road

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 N. Mt. Royal Ave.

(a) FEB 5 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Febr 1946 to Febr 1946 and that I last saw him alive on Febr 1946

Immediate cause of death	Duration
Cardiac insufficiency	2 days
Due to Senility and La Grippe	1 day
Due to	
Other Conditions Pulmonary Edema	2 Weeks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lorenz Grossardt M. D.
Address 437 Maryland Ave Date signed 2-4-46

VS 150

(1894)

Consult age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G37117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G37117

Please write the causes of death clearly and legibly. Physicians: please write plainly; important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Crofton Road (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James D Shea

3 (b) If veteran, name war: W War #1

3 (c) Social Security Account No. * *

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa Hodges Shea

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Oct 11 - 1899

8. AGE: Years 46 | Months 3 | Days 23 | If less than one day ....hr. ....min.

9. Birthplace Deer Hills - Mt Washington (Town) Baltimore (County) Md (State)

10. Usual Occupation Lawyer

11. Industry or business a

FATHER
12. Name Dennis Shea
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Dawson
15. Birthplace Maryland

16 (a) Informant Rose Hodges Shea
(b) Address 1318 Crofton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/46 (month) (day) (year)
(c) Cemetery Baltimore National
Location Frederick Road

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt Royal Ave

19 (a) FEB 5 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Feb 1946, at 11:15 P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

Immediate cause of death	Duration
Asphyxiation	
Due to Illuminating Gas	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Suicide
(b) Date of occurrence 4 Feb 46
(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Open gas burners on Stove

23. Signature William F Hedges M.D. Medical Examiner.
Date signed 5 Feb 46

VS 6

G37118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G37118

Write the causes of death clearly and legibly. Typewriting preferable; pencil not acceptable. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5107 Greenhill Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Greenhill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH S. KRAMER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife August J.
6 (c) If alive, give age years

7. Birth-date of deceased (mo., day, yr.) Oct. 18-1883

8. AGE: Years	Months	Days	If less than one day
62	3	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Bernard Zinkand
13. Birthplace Germany

MOTHER
14. Maiden Name Schmidt
15. Birthplace

16 (a) Informant Mr. August J. Kramer
(b) Address 5107 Greenhill Ave
17 (a) Burial (b) Date thereof 2.8.46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Leonard J. Keck
(b) Address 5305 Harford Rd.
19 (a) (Date rec'd by local registrar) (b) Registrar

FEB 5 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/46, 19, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2/4/46

93D

G37119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G37119

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood - Greene
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Curran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wh	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1904

8. AGE: Years	Months	Days	If less than one day
41	1	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John J. Curran
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Halsey
15. Birthplace Md

16 (a) Informant Mrs Mary E Anderson
(b) Address 1209 W Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Longwood & Whitelock Sts

18 (a) Funeral director Chas L Corrin Sons
(b) Address 901 N Howard St

19 (a) Date rec'd by registrar (b) Huntington Williams M.D. Registrar

FEB 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1946, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1946, to 2-4 1946 and that I last saw h alive on 2-4 1946

Immediate cause of death Gastric Hem.

	Duration
Due to Esophageal Varices	
Due to Cirrhosis of Liver	
Other Conditions Diabetes Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy Cirrhosis of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Butler M. D.

Address Univ. Hospital, Date signed 2-7-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G37120
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave.
(c) Hospital or institution: Sinai Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B. A. Co.
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 Doris Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Cuddy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bernard E. Cuddy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10-1909

8. AGE: Years 36 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Otto Brauns

13. Birthplace Germany

MOTHER 14. Maiden Name Eva Reynolde

15. Birthplace West Virginia

16 (a) Informant Bernard E. Cuddy

(b) Address 223 Doris Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-1946 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1426 Light St. Baltimore, Md.

19 FEB 5 1946 (b) Hunting for Baltimore, Md. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1946, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1946 to 2-3 1946 and that I last saw her alive on 2-3 1946

Immediate cause of death: Rheum. Heart Disease — Duration 15 yrs

Due to: Mitral insuff - mitral stenosis

Due to: Bad valve Thrombus Pulmonary infarction

Due to: Cardiac decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Katz M. D.

Address Sinai Hosp Date signed 2-4-46

X Balt Md

VS 150

G37121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. G37121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. Gay Sts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James McGrady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married~~, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14-1896

8. AGE: Years 54 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Frostburg Md
(Town, county and state)

10. Usual Occupation Steamfitter

11. Industry or business

FATHER
12. Name Richard Mc Grady
13. Birthplace Maryland

MOTHER
14. Maiden Name Mrs Bernard Adams
15. Birthplace Cumberland Md

16 (a) Informant Mrs Bernard Adams
(b) Address

17 (a) Burial (b) Date thereof 2-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Cumberland Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) FEB 5 1946 Hunting for Williams, H.F.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946, at 12:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. F. Schleicher M.D.
Medical Examiner.
Date signed 2/3/46

VS 151

G37122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G37122

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3600 Fait Ave.
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Almost 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA STRUZINSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Struzinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) -1-1-1893.

8. AGE: Years	Months	Days	If less than one day
52	1	1	hr. min.

9. Birthplace Austria (Town, county and state)
10. Usual Occupation Stone-Cutter.
11. Industry or business Grocery.

FATHER
12. Name Francis Dobrowolski
13. Birthplace Austria

MOTHER
14. Maiden Name Unknown.
15. Birthplace Austria

16 (a) Informant Joseph Struzinski (Husband)
(b) Address 3600 Fait Ave.

17 (a) Burial (b) Date thereof 2-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Ave. Balto, Md.

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Fait Ave.

19 (a) FEB 5 1946 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2.2.46 19 , at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1945 to 2-2 1946 and that I last saw h alive on 1-6 19 46

Immediate cause of death Carcinomatosis — Duration 9 mo.
Due to —
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation June 1945
Major findings of operation: Carcinoma
Biopsy
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence M. Lenz M. D.
Address 11 E. Chase St. Date signed 2.2.46

G37123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

Registered No. G37123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Broadway St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola Moir

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2656

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Thomas Moir

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1900

8. AGE: Years	Months	Days	If less than one day
45	1	10	hr. min.

9. Birthplace Youngstown Ohio (Town, county and state)

10. Usual Occupation Meat Packer

11. Industry or business Oppman Packing Co.

FATHER
12. Name Albert Marshall
13. Birthplace Youngstown Ohio

MOTHER
14. Maiden Name Catherine Mac Cabe
15. Birthplace Youngstown Ohio

16 (a) Informant Jane Moir
(b) Address 1032 Broadway Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9 1946 (month) (day) (year)

(c) Cemetery or crematory Arlington U.S. National
Location Arlington Virginia

18 (a) Funeral director Wendel Lobinger
(b) Address 2152 Reisterstown Ave

19 (a) DEC 5 1946 (Date rec'd by local reg.) (b) Huntington West Virginia (Place of death)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gabrielson M.D. (Medical Examiner.)
Date signed Dec 1 46

637124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 637124

Every item of information should be carefully supplied. Write plainly, with UNFADING INK. Physicians: please write the correct age is especially important. Refers to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15 days
(e) Length of stay in Baltimore (yrs., mos., or days): 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1431 Woodall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Usher, William Frederick

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Eva T. Beall
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1903

8. AGE: Years	Months	Days	If less than one day
43	0	8	hr. min.

9. Birthplace: ? England
(Town, county, and state)
10. Usual Occupation: Chief engineer
11. Industry or business: seafarer

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-46 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Annapolis Blvd.

18 (a) Funeral director: Chas. F. Dill
(b) Address: 1501 E. Fort Ave.

19 (a) FEB 5 1946 (Date rec'd by registrar) (b) Entering for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1946, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1946, to Feb. 2 1946 and that I last saw h im alive on Feb. 2 1946.

Immediate cause of death	Duration
#1- Pulmonary tuberculosis	Unknown
#2- Tuberculous laryngitis	Unknown
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed 2/4/46
US Marine Hospital, Balto, Md.

G37125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37125 (duplicate)

830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4016 Eldorado Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Eldorado Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLE CASTLE SIMMONS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Edward B. Simmons
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct. 19, 1867
8. AGE: Years 78 | Months 3 | Days 15 | If less than one day hr. min.
9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: James D. Spangler
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Euna Ray
15. Birthplace: Prince George Co., Md.

16 (a) Informant: Mr. Herschel K. Simmons
(b) Address: 4016 Eldorado Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

FEB 5 1946 (a) (Date rec'd by registrar) (b) Huntington W. Willis, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 4, 1946, at 5:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1945 to Feb 1946 and that I last saw her alive on Feb 3 1946.

Immediate cause of death: Cerebral Vascular Accident — Duration: 2 days
Due to: Generalized Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Thos G Abbott M. D.
Address 4509 Liberty H. Ave. Date signed 2-5-46

Physicians: please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G37126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G37126 Registered No.

Please write or type information. Physicians: please write the correct age is especially important. Be careful to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Aves
(c) Hospital or institution: Md General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 Kirk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGANNA MURPHY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Detective Sergeant James P. Murphy (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1877

8. AGE: Years	Months	Days	If less than one day
68	11	16	hr. min.

9. Birthplace Chambersburg Pa (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business at Home

FATHER
12. Name William Silvers
13. Birthplace Chambersburg Pa.

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Det. Serg. James P. Murphy
(b) Address 2929 Kirk Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount & Hoffman Sts

18 (a) Funeral director Chas. W. Conaway & Son
(b) Address 924 E. Eager St.

19 (a) (b) Williams M.D. Registrar

FEB 5 1946 Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/46 19 , at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1946, to 2/5 1946, and that I last saw her alive on 2/5 1946.

Immediate cause of death UREMIA — Duration 2 D. days

Due to HYPERTENSIVE DISEASE

Due to DIABETES MELLITUS

Other Conditions TERMINAL HYPO-STATIC PNEUMONIA
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M.D.
Address Maryland Gen. Hosp. Date signed 2/5/46

X

G37127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G37127

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland City
(b) Street address Reisterstown Rd & Patterson ave
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo-20 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo-20 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town La Plata (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Angela M. Vacchiano
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1878

8. AGE: Years 67 | Months 11 | Days 16 | If less than one day: hr. min. 15

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Angelo Alfieri
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location La Plata Md

18 (a) Funeral director Hunt & Ryan
(b) Address Waldorf Md

19 (a) 1/6/46 (Date rec'd by registrar) (b) A W Hedrick Registrar
Huntington Hillcrest, Md

FEB 5 160 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1946 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Jan. 4 1946, and that I last saw h.e.r alive on Jan 4 1946.

Immediate cause of death Reputed Coronary Occlusions — Duration 6 Mo.
Due to Diabetes Mellitus
Due to Arteriosclerosis
Other Conditions Involutional Melancholia — 6 Ms.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Algire M. D.
Address 3326 Hendrick Ave. Date signed

G37128 City

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a ★

G37128 Registered No. 15

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address #10 Shore - Curtis Creek.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. #10 Shore - Curtis Creek (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nettie M. Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Andrew C - Gray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1878

8. AGE: Years	Months	Days	If less than one day
67	11	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Henry
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Harriett Saur
(b) Address 2121 Hawkins Pt. Rd. Curtis Bay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5- 46 (month) (day) (year)
(c) Cemetery or crematory Crumpton Cem.
Location Crumpton, Md.

18 (a) Funeral director Edgar L. Lane
(b) Address Church Hill Md.

19 (a) Jan 8/46 (Date rec'd by registrar) (b) I do M. Whitson (Registrar)

FEB 5 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 3 1946, at 12.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-29 1945, to JAN-1 1946, and that I last saw her alive on JAN-1 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hyper Tention	
Due to Arteris-Sclerosis-	
Other Conditions Bronchial Pneumonia-	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joel Lattimer M. D.
Address 420 Date signed 1/3/46

G37129 CWE-98935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37129 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Richardson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olshuski, Joseph (OLECHOWSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-07-7382

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
63 ?	?	?	hr. min.

9. Birthplace Not Known
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b)
Date rec'd by Local Reg. FEB 8 1946 Huntington Williams, Reg.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1946, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1945 to Feb. 3 1946, and that I last saw him alive on Feb. 3 1946.

Immediate cause of death Coronary Thrombosis — Duration ?

Due to Arteriosclerotic Heart Disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Jernigan M. D.

Address Baltimore City Hosp. Date signed 2-4-46

correct age is especially important. Physicians: please write the

B 37130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yr
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ora Louise Berringer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 90 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Andrew
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sarah Litsinger
15. Birthplace Penna.

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) FEB 5 1946 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946, at 6-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946, to Feb 5 1946, and that I last saw her alive on Jan 4 1946

Immediate cause of death	Duration
Edema Lungs	5 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E Northern Date signed 2/5/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37131 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Conray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Laura Dayton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 [illegible] 66

8. AGE: Years	Months	Days	If less than one day
79	2		hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Martin Conray
13. Birthplace Ireland

MOTHER
14. Maiden Name Nora Doosy
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by Registrar) FEB 5 1946 (b) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4- 1946, at 3-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1- 1946, to Feb 4- 1946, and that I last saw him alive on Feb-4- 1946.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 E North Av Date signed 2/5/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G37132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G37132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Tuttle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Francis Tuttle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8th 1874

8. AGE: Years 71 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md U.S.A.
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Joseph Podgnuk
13. Birthplace ?

MOTHER
14. Maiden Name Mary Smyczal
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (b) Date thereof Feb 6 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) FEB 5 1946 (b)
(Date rec'd by registrar) Registrar

Clayton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1946, to Feb 4 1946, and that I last saw him alive on Feb 3 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arterio-Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E Northern Date signed 2/5/46

VS 150

correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. The ... UNFADING INK. ... the causes of death clearly and legibly.

G37133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G37133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Booth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys May Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/13/34

8. AGE: Years: 11 | Months: 4 | Days: 17 | If less than one day hr. min.

9. Birthplace Macon, N.C (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Louis Jones
13. Birthplace N.C.

MOTHER
14. Maiden Name Carrie M. Falkner
15. Birthplace Va.

16 (a) Informant Carrie M. Jones
(b) Address 433 N. Fulton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradshaw Ave

19 (a) FEB 5 1946 (Date rec'd by registrar) Hunter for Mathieson M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 19 46 at 1:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Caseous Tubercular pneumonia.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner
Date signed 1-30-46

VS 151

Fill in the causes of death clearly and legibly. Physician: please write the

G37134 BALTIMORE CITY HEALTH DEPARTMENT G37134

CERTIFICATE OF DEATH 1706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Pamplin
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doctor Connie Baldwin

3 (b) If veteran, name war World War I

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 17-1896

8. AGE: Years 49 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Appomattox Co. Va
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Doctor Joseph T Baldwin
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Jane Fore
15. Birthplace Va.

16 (a) Informant Rosa Mae Baldwin
(b) Address Virginia

17 (a) Burial (b) Date thereof Feb-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baldwin
Location Pamplin Va.

18 (a) Funeral director Thomas F. Kenny Inc.
(b) Address Hollins & Gilmor Sts.

19 (a) (b)
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1946, at 10:35 AM

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: Doctor Bal.
(a) Date of injury February 3, 1946 M.
(b) Where did injury occur? Wash. Blvd nr Fulton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by truck

23. Signature Robert L. Fulton M.D.
Medical Examiner.
Date signed 2-4-46

VS 151

Routing for Williams, Md

G37135 ✓ G37135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Old Orchard Road
(c) Hospital or institution: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town 517 Old Orchard Rd. Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Joseph Garrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: May Hubbard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/62

8. AGE: Years 83 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Phila., Pa. (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Jonathan Swain Garrison
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Johnson
15. Birthplace ?

16 (a) Informant Mrs. Ruth G. Tucker
(b) Address Corpus Christi, Texas

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Spring Hill
Location Easton, Md.

18 (a) Funeral director John M. Mitchell & Sons
(b) Address 1901 Eutaw Place

19 (a) FEB 6 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Feb 4 1946 and that I last saw h[illegible]m alive on Feb 4 1946

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Duodenal ulcer	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Duodenal ulcer with scarring of duode[illegible]

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Thomas, Jr. M.D.

Address Maryland Hosp Date signed 2/4/46

Physician for Williams, M.D.

X

VS 150

correct age is especially important. Physicians: please write the

G37136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 13

Registered No. G37136

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John Sts.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 CHESMONT AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE MAE SOYKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband ~~or wife~~ CHARLES T. SOYKE
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) MARCH 27, 1905

8. AGE: Years	Months	Days	If less than one day
40	10	8	hr. min.

9. Birthplace ALTOONA, PENNSYLVANIA
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name CHRISTOPHER H. MASTERSON
13. Birthplace ALTOONA, PENNSYLVANIA

MOTHER
14. Maiden Name MINNIE L. MASTERSON
15. Birthplace ALTOONA, PENNSYLVANIA

16 (a) Informant CHARLES T. SOYKE
(b) Address 4003 CHESMONT AVE

17 (a) Burial (b) Date thereof 2/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Taylor Ave.

18 (a) Funeral director Howard M. BLIGHT, Jr.
(b) Address 4914 BELAIR ROAD

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 3 1946, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 1 1946, to FEB. 3 1946, and that I last saw her alive on FEB. 3 1946.

Immediate cause of death	Duration
RHEUMATIC CARDIOVASCULAR DISEASE; MITRAL + TRICUSP STENOSIS + INSUFFICIENCY; Hydrothorax, Bilateral, Marked Hydropericardium Hydroperitoneum	0
Other Conditions Unresolved Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation Not Performed
Major findings of operation: ABOVE
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Richard Compton M. D.
Address Hospital for Women Date signed 2 Feb 46

VS-100
FEB 6 1946 Huntington Williams, M.D.

C37137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C37137 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 S. Albemarle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 S. Albemarle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Anikis (Einikis)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John Anikes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ?

13. Birthplace Lithuania

MOTHER 14. Maiden Name ?

15. Birthplace Lithuania

16 (a) Informant Joseph Anikes

(b) Address 30 S. Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Joseph Kasinskas

(b) Address 602 Washington Blvd

19 (a) FEB 6 1946 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5-1943 to 2-5-1946, and that I last saw h[illegible] alive on 2-4-1946.

Immediate cause of death: Cerebral tumor Lung — Duration 3 YRS

Due to Hypertension Cardio

Due to vascular dis - ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Kelly M.D.

Address 527 E. York Balto 2/6/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G37138 | BALTIMORE CITY HEALTH DEPARTMENT | G37138

CERTIFICATE OF DEATH 1310 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 Guilford ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2302 Guilford ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancey Corley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Peter Corley
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9-26-1877

8. AGE: Years 68 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Charles Brown
13. Birthplace S. C.

MOTHER
14. Maiden Name Sallie ?
15. Birthplace S. C.

16 (a) Informant Maggie Taylor
(b) Address 2309 Guilford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 6 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto County Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) FEB 6 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1946 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Feb 2 1946 and that I last saw h— alive on Feb 2 1946

Immediate cause of death

	Duration
Cardiac Renal Disease	Stud
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Johnson M. D.
Address 2329 Guilford ave Date signed Feb 6 1946

VS 150

X

G37139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /37a

G37139
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Pennsylvania Avenue
(If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME David Strother

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-1893

8. AGE: Years	Months	Days	If less than one day
52	4	21	..... hr. ..... min.

9. Birthplace D. C.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Julia Brown
(b) Address 1109 Penna. ave.

17 (a) Burial (b) Date thereof 2 8 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Memo. Cem.
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 (a)..... (b).....
(Date received by registrar) Huntington Williams, M.D. Registrar

FEB 6 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1946 at 10 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Benign Prostatic Hypertrophy; Marked hypertrophy & dilatation of bladder

Due to Chronic pyelonephritis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Fratarcangeli M.D.
Medical Examiner.
Date signed Feb. 5 1946

X

G37140 BALTIMORE CITY HEALTH DEPARTMENT G37140

CERTIFICATE OF DEATH 912 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1055 Argyle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1055 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marjorie Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Theodore Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14 1906

8. AGE: Years 39 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Spencer Lee
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Sophie Ware
15. Birthplace Washington D.C.

16 (a) Informant Theodore Davis Clifford
(b) Address 924 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Wm. Roger R. Williams
(b) Address 2229 W. Lehmonder St.

19 (a) (b) Huntington Williams M.D.

FEB 6 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1946, at 1 20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis Acute
Vegetative Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fortune M.D.
Medical Examiner.
Date signed Feb 1 1946

G37141 X ✓ G37141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Cerastene Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Owens Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed or divorced. Widowed

6 (b) Name of husband or wife John L. Kraft

6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) 2/23/1856

8. AGE: Years 89 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Francis Owens
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Riley
15. Birthplace Ireland

16 (a) Informant Reece R. Bowie Jr. M.D.
(b) Address University Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1946 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Georges A. Farley
(b) Address Fulton ave. & Fayette St.

19 (a) FEB 6 1946 (b) Huntington Hillsville, Md.
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1946, at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1945 to Feb 4 1946, and that I last saw her alive on Feb 4 1946

Immediate cause of death: Hypostatic Pneumonia — Duration

Due to: Fracture of Right Hip.

Due to:

Other Conditions: Diabetes Ulcers.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-30-45 at M
(c) Where did injury occur? Catonsville Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall on Floor

23. Signature Reece R. Bowie Jr
Address University Hosp. Date signed 2-5-46 M. D.

Howard J. Mercer, M.D.

VS 150

correct age is especially important. Physicians: please write the

G37142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G37142

Please write plainly with pen or pencil. Do not use ink. Make no abbreviations. Report one death only on this certificate. Fill all items. Use "None" or "Unknown" where necessary. If the cause of death is not definitely known, state the conditions which probably caused death. Sign certificate and see that it is filed with the Registrar of the district in which death occurred before the body is removed.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Fawnes Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Thomas Monroe

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife Flora Bessie Monroe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Lancaster Co. Va. (town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Orson Monroe
13. Birthplace Va.

MOTHER
14. Maiden Name Ida Bascol
15. Birthplace Va.

16 (a) Informant Flora Bessie Monroe
(b) Address 1521 E. Garnett St.

17 (a)..... (Burial, cremation, or removal) (b) Date thereof 2-11-46 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore City

18 (a) Funeral director Geo. G. Kelson
(b) Address 630 Westminster St.

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

FEB 10

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3-1946, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, ventricular, Spontaneous

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-4-46

VS 151

Huntington

G394143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G37143 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mos. 28days
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1851 Lorman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18-1941

8. AGE: Years	Months	Days	If less than one day
4	4	15	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Pearlie Lee Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Francis Jackson
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. Va
Location Va

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pressman St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 6 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1946, at 10:28 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1945, to 2-3 1946
and that I last saw h[illegible] alive on 2-3 1946.

Immediate cause of death Uremia
Heart Failure — Duration: Upon

Due to Chronic Nephritis (Nephrotic Syndrome) — Duration: 1 year

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E Baylutt M. D.
Address Balt. City Hosp. Date signed 2-4-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G37144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G37144 Registered No.

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Goodmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/17

8. AGE: Years 28 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Suffolk, Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Albert Goodman
13. Birthplace N. C

MOTHER
14. Maiden Name Maggie Clay
15. Birthplace Va.

16 (a) Informant Beatrice Parker
(b) Address 1220 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave
(c) Place Washington Williamsburg Va

FEB 6 1946 (Date rec'd) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1946 to Feb 3 1946 and that I last saw h[illegible] alive on Feb 3 1946

Immediate cause of death: Peritonitis - Diffuse — Duration 2 days
Fibro Purulent
Due to Possible Salpingitis
Due to
Other Conditions Carcinoma Syndactilia — 1 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Diffuse Peritonitis, Cause

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard F Kuland
Address University Hosp Date signed 2/7/46

VS 150

over

G37145

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G37145 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wilkins + Catonsville
(c) Hospital or institution:
St. Agnes Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Prince George
(a) State Md (b) County Baltimore
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Main St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ada Gibbons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26 1876

8. AGE: Years	Months	Days	If less than one day
69	10	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward Hantt
13. Birthplace Maryland

MOTHER
14. Maiden Name Murray
15. Birthplace Maryland

16 (a) Informant Daughter - Jeanette Gibbons
(b) Address 160 Arbutus Place N.W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 7 46 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Laurel Md

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md Williamsville, Md

19 (a) FEB 6 1946 (b) Huntington Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1946, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1946, to 2/4 1946, and that I last saw h.c. alive on 2/4 1946.

Immediate cause of death	Duration
Cardio-Resp failure	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cecil Roberts D-M-D

Address 39 Agnes Hosp Date signed 2/4/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G37146 Registered No. G37146

G37146

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 Pontiac Ave (25)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Pontiac Ave (25) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliena Palmer Owen

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm. H. Owen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1-1862

8. AGE: Years 84 Months 1 Days 4 If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Edward Hamlett
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Harvey
15. Birthplace Virginia

16 (a) Informant Mr Walter T Owen
(b) Address 532 Pontiac ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Va
Location Old Harvey Home Cemetery

18 (a) Funeral director Milton S Spridling
(b) Address 3914 E. Hanover St (25)

19 (a) (Date rec'd by registrar) Registrar

FEB 6 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1946, at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 5 1946. and that I last saw h[illegible] alive on Feb 5 1946

Immediate cause of death	Duration
1 Terminal Pneumonia	2 days
Due to Hemaplegia	5 days
Due to Cerebral Hemorrhage	5 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Lulin

Address 320 Patapsco Ave Date signed 2/5/46 M. D.

Huntington Williams, M.D.

G37147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G37147 Registered No.

Please answer questions on death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Howard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances McKinney

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Gardenhour
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Woolard
15. Birthplace Va

16 (a) Informant Lessie Jordan
(b) Address 307 County St Suffolk Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto

18 (a) Funeral director Isaiah L Brown Sons
(b) Address 1001 W Montgomery St

19 (a) Date rec'd (month) (day) (year) Huntington Williams Md

FEB 6 1946

OS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1- 1946, at 1:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH

Acute Congestive Cardiac Failure

Due to

Other Conditions Hypertrophy of heart - Edema of brain.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D.
Medical Examiner.

Date signed 2-1-46

X

G37148

AB- 97300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G37148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bombhardt or Charles Bombhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-9842

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18-1907

8. AGE: Years	Months	Days	If less than one day
38	5	15	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer Supply Co.
11. Industry or business

FATHER
12. Name George Rhinehardt Bombhardt or Bombhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Mamie Myers 'D'
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Oakleawn
Location Eastern Ave.

18 (a) Funeral director C. P. Schimunek
(b) Address 2601-03 E. Madison St.

19 (Date rec'd by registrar) FEB 6 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3- 1946 at 11.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14- 1945 to 2-3 1946 and that I last saw h. alive on 2-3- 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert H. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 2/4/46

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 637149

Please answer all questions. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 S. Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 1102 S Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard S. Kirby

3 (b) If veteran, name war: World war I

3 (c) Social Security Account No. 217-01-0937

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bertha M Kirby

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 15" 1872

8. AGE: Years 73 | Months 5 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Marine Police Man

11. Industry or business Shipping Business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs. Bertha M. Kirby
(b) Address 1102 S. Lakewood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7-1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Eastern Ave

18 (a) Funeral director Stephen J. Galbreath Inc
(b) Address 1000 E. Lenwood ave

19 (a) FEB 6 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1946, at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Feb 4 1946 and that I last saw h[illegible] alive on Feb 4 1946.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Chronic Nephritis	
Due to Coronary Thrombosis	1-2-44
And Coronary Occlusion	Feb 4 46
Due to	
Other Conditions Fever	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E A Schumacher M. D.

Address 842 N Eutaw Date signed 2-6-46

VS 150

X

G37150 BALTIMORE CITY HEALTH DEPARTMENT G37150

CERTIFICATE OF DEATH 157E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Gardners (If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. #2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Hays
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-8-44

8. AGE: Years 1 | Months 9/10 | Days 27 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Hays
13. Birthplace Pa

MOTHER
14. Maiden Name Bertha Meyers
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8 1946 (month) (day) (year)
(c) Cemetery or crematory Uriah
Location Gardners RD2 Penna.

18 (a) Funeral director George B Ruterg
(b) Address Bonfleronda Pa

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 6 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946 at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1946 to Feb 5 1946 and that I last saw h[illegible] alive on Feb 5 1946

Immediate cause of death Congenital Heart disease Cyanotic type
Due to Pulmonary Stenosis of Tetralogy of Fallot
Due to
Other Conditions

Duration
Life — 2 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Greenwood M.D.
Address Johns Hopkins Date signed Feb 6 1946

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58B

Registered No. G37151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Wiggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Norman Wiggins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 31 Months Days If less than one day hr. min.

9. Birthplace Kilmarnock, Virginia
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business home

FATHER
12. Name Simon Conquest
13. Birthplace Virginia

MOTHER
14. Maiden Name Viola Wright
15. Birthplace Virginia

16 (a) Informant Norman Wiggins
(b) Address 1510 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/46 (month) (day) (year)
(c) Cemetery or crematory Lancaster
Location Lancaster Co. Va.

18 (a) Funeral director Geo. W. Nelson
(b) Address 1303 Presstman St

19 Filed FEB 6 1946 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1946, at 2P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23, 1946 to Feb 4, 1946 and that I last saw her alive on Feb 3, 1946

Immediate cause of death Septic Endocarditis with Acute Cardiac Dilatation — Duration: one week

Due to Acute Rheumatic fever — Duration: 13 days

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. J. Campbell M. D.
Address 639 N. Carey St Date signed 2-6-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G37152

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1804 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rupert H. Nelson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife George W. Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1905

8. AGE: Years 40 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Nugh
13. Birthplace Md.

MOTHER
14. Maiden Name Deaire
15. Birthplace Md

16 (a) Informant George W. Nelson
(b) Address 1804 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/46 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Pk
Location Md.

18 (a) Funeral director Robert L. Young
(b) Address 8041 N. Caroline St

19 (a) Date rec'd by local reg. FEB 6 1946 (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1946 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1945 to 2/3 1946 and that I last saw h live on 2/3 1946

Immediate cause of death Acute Leukemia — Duration 8 mo

Due to Hepatitis, due to — 5

Due to Staphylococcus — 3 hrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Hafeker

Address 1725 Pa Ave Date signed 2/5/46

X

Red Exam Call
G37153 Hap

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 66B

Registered No. G37153

Incorrect age is especially important. Physicians: please write the information called for carefully and legibly. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4323 Kolb Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melanie Ann Grealy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-45

8. AGE: Years | Months: 6 7 | Days: 25 | If less than one day hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Edward Grealy
13. Birthplace: Balto

MOTHER
14. Maiden Name: Marguitte Hartline
15. Birthplace: Balto

16 (a) Informant

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 6 46 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer
Location: 4300 Belair Rd

18 (a) Funeral director: Martin E. Riegel
(b) Address: 7110 Belair Rd

19 (a) (Date received by Registrar) (b) Huntington Hill Registrar

FEB 6 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946 at 2 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1946 to Feb 5 1946 and that I last saw her alive on Feb 5 1946.

Immediate cause of death Shock dehydration — Duration: DOA

Due to Vertebrae and Congenital maldevelopment

Due to with dwarfism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Agenesis of the hypoplasia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nedra A. Nazar M. D.
Address Johns Hopkins Hospital Date signed 2-6-46

G37154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 36

Registered No. G37154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1641 Lorman Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 Lorman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winifred Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1944 Infant

8. AGE: Years 1 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Geo. W. Smith
13. Birthplace D. C.

MOTHER
14. Maiden Name Elsie Wms
15. Birthplace Wash. D. C.

16 (a) Informant Geo. W. Smith
(b) Address 1641 Lorman Ct

17 (a) Burial (b) Date thereof 2/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Pressman St

19 (a) (b)
(Date received by registrar) Registrar

FEB 6 1946 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Feb 1946, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rubeola

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.
Date signed 5 Feb 46

X

G37155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37155 Registered No. 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2514 Grunmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2514 Grunmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gaetana De Benedetto

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Rocco De Benedetto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1864

8. AGE: Years 81 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carmine Di Dacco
13. Birthplace Italy

MOTHER
14. Maiden Name Philomena Rossi
15. Birthplace Italy

16 (a) Informant Anthony De Benedetto
(b) Address 523 N Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Tilhom & Son
(b) Address 1217 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946, at 6 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 4 1946, and that I last saw her alive on Feb 4 1946.

Immediate cause of death Cardio-Respiratory Paralysis — Duration

Due to Arterio Sclerosis & — Duration

Due to Chronic Nephritis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. V. Clift
Address 5010 Greenleaf Rd Date signed 2-5-46 (M. D.)

X

correct age is especially important. Physicians: please write the

G37156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B G37156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2935 ST PAUL STREET.
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2935 ST PAUL STREET.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME: HARRY D. HARVEY.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Mary C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1-1868

8. AGE: Years	Months	Days	If less than one day
77	8	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Manufacturer
11. Industry or business Retired

FATHER
12. Name John Edward Harvey
13. Birthplace Md

MOTHER
14. Maiden Name Bernie M.E.D Harvey
15. Birthplace Md

16 (a) Informant Harold Harvey
(b) Address 2935 St Paul St

17 (a) Burial (b) Date thereof 2/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director William Cook Inc
(b) Address 1212 St Paul street

19 (a) FEB 6 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 5 1946, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 12 1944 to FEBY 5 1946 and that I last saw him alive on FEBY 5 1946.

Immediate cause of death ACUTE CARDIAC DILITATION FEBY 5 1946 — Duration 6

Due to CHRONIC MITRAL REGURGITATION — 1944

Due to CHRONIC MYOCARDIAL DEGENERATION .44

Other Conditions ARTERIOR SCLEROSIS 1944.
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, or industrial place)
(e) Means of injury

23. Signature Chas P Chanticie M. D.
Address 3013 ST PAUL ST Date signed FEBRUARY 5 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G37157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37157 Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 E. 35th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. 35th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Gretzinger

3 (b) If veteran, name war 1917 | 3 (c) Social Security Account No. none

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1888

8. AGE: Years 62 | Months 4 | Days 6 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER 12. Name Charles Gretzinger
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Brooks
15. Birthplace Germany

16 (a) Informant Elizabeth Gretzinger
(b) Address 612 E 35th St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2 8 46 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem
Location Baltimore Md

18 (a) Funeral director Wilson Colvin
(b) Address 1317 St Paul St

19 (a) FEB 6 1946 (Date rec'd by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1946 at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1944 to Feb. 5 1946 and that I last saw h[illegible] alive on Feb 1 1946.

	Duration
Immediate cause of death: Coronary occlusion	few minutes
Due to: Hypertension & Coronary sclerosis	3 yrs.
Due to:	
Other Conditions: Cerebral arterio sclerosis — (Include pregnancy within 3 months of death)	1 yr.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Dallas L. Baggott M.D.
Address 3812 Gramont Ave Date signed Feb 3 1946

Flemington [illegible]

X

G37158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G37158 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St.
(c) Hospital or institution: Home for Incurables - 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Same.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Weinhardt.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1869

8. AGE: Years 76 | Months 10 11 | Days 16 15 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Maniek
13. Birthplace Germany -

MOTHER
14. Maiden Name Willamina Hossy.
15. Birthplace Germany -

16 (a) Informant Records of Home for Incurables
(b) Address 700 West 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Tallhorn & Cook Inc.
(b) Address 1217 E. Cold St.

19 (a) FEB 6 1946 (Date received by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1946, at 4½ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1926, to 2/4 1946, and that I last saw h[illegible] alive on 2/4 1946.

	Duration
Immediate cause of death: Enteritis - 2 Fistula	
Hemorrhage - probably due to Cancer of Stomach	3 Months
Due to	
Due to	
Other Conditions: Rheumatoid Arthritis	29 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Hartzog M. D.
Address 214 Mitchell Crt. Bldg. Date signed 2/6/46

X

G37159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

G37159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1888

8. AGE: Years 57 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Buckingham Co Va.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Ford

13. Birthplace Va

MOTHER 14. Maiden Name Margaret Eldridge

15. Birthplace Va.

16 (a) Informant Oakley Peake

(b) Address 845 Edmondale Rd.

17 (a) Removal (b) Date thereof Feb 7/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Bremo Va

18 (a) Funeral director Mrs Robert A. Elliott Dept

(b) Address 1129 N. Caroline St.

19 (a) FEB 6 1946 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1946, at 7.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William G Stafford M.D.
Medical Examiner.

Date signed 5 Feb 46

Huntington Williams, M.D.

G37160 G37160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 N. Mount Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Eliza Jane Jones

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James W.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4, 1864

8. AGE: Years 81 | Months 8 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Long Green, Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER
12. Name Daniel Quickley
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Louisa Curtis
15. Birthplace Baltimore, Md.

16 (a) Informant Walter R. Jones
(b) Address 711 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) ..... (b) ..... (Date rec'd by Registrar) FEB 8 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1946 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to Feb. 3 1946 and that I last saw her alive on Feb. 3 1946

Immediate cause of death	Duration
Congestive heart failure	3 month
Due to Essential Hypertension	?
Due to Arteriosclerosis	?
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: .....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature George McDonald M. D.
Address 844 W. Carey St. Date signed 2/5/46

correct age is especially important. Physicians: please write the name or nature of infirmities should be carefully supplied. The causes of death clearly and legibly.

VS 150

637161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1330

Registered No. 637161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address NORTH BROADWAY
(c) Hospital or institution CHURCH HOME & HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE A. CULLEN

3 (b) If veteran, name war: 0

3 (c) Social Security Account No.: 0

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Charles C. Cullen

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 13, 1870

8. AGE: Years 75 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace St. Mary's Co., Maryland (Town, county, and state)

10. Usual Occupation Home

11. Industry or business —

FATHER
12. Name Geo Rowan Barnes
13. Birthplace Maryland (St. Mary's Co.)

MOTHER
14. Maiden Name Lucie Graves
15. Birthplace Maryland

16 (a) Informant Florence Cullen
(b) Address 1834 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 6 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 5 1946 at 1 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28- 1946 to 2-5 1946 and that I last saw her alive on 2-5 1946

Immediate cause of death	Duration
UREMIA	
Due to HYDRONEPHROSIS	
Due to CHRONIC PYELITIS	
Other Conditions	

Other Conditions: LEFT CERCBROVASCULAR ACCIDENT (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: HYDRONEPHROSIS; CHRONIC PYELITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B Little Jr. M.D.
Address Church Home & Hosp. Date signed 2-5-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G37162 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Morgue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 752 Reservoir St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Flora Windsor

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife William Windsor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Montgomery Co., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hezekiah Leaman
13. Birthplace Montgomery Co., Md.

MOTHER
14. Maiden Name Virginia Dowdey
15. Birthplace Va.

16 (a) Informant Miss Leaman
(b) Address 752 Reservoir St.

17 (a) Burial (b) Date thereof 2/8/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Gaithersburg, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 6 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5th 1946, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an INSP. & INQ. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skinkarlic M.D.
Medical Examiner.
Date signed 2-5-46

VS 151

the causes of death clearly and legibly.

G37163

BALTIMORE CITY HEALTH DEPARTMENT X G37163 Registered No.

CERTIFICATE OF DEATH

H57867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County Preston
(c) City or town Tunnelton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William lo Shannon.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	

6 (b) Name of husband or wife
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 9-25-90

8. AGE: Years	Months	Days	If less than one day
55	4	10	hr. min.

9. Birthplace W. Va
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Morgan Shannon
13. Birthplace W Va

MOTHER
14. Maiden Name Susie L.
15. Birthplace W. Va.

16 (a) Informant Ramona.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9/1946 (month) (day) (year)
(c) Cemetery or crematory
Location Tunnelton W. Va

18 (a) Funeral director Ocie Funeral Home Inc.
(b) Address 4684 York Rd.

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

FEB 6 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5th 1946 at 1.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1946 to Feb. 5 1946 and that I last saw him alive on Feb. 5 1946.

Immediate cause of death Brain tumor — Duration
First recumbent —
Post operative.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 2/3/46
Major findings of operation: Brain tumor — glioma — Rt. temporal lobe
of autopsy — Incomplete Rt temporal lobe.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul W. Dawbors
Address Johns Hopkins Hospital Date signed 2/5/46

X

Correct age is especially important. Physicians: please write the

G37164 — Thomas J. Grady — G37164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1622 Holbrook St.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Holbrook St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Grady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Nora C. Grady
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 11-10-1885

8. AGE: Years	Months	Days	If less than one day
64	2	25	..... hr. ..... min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Sydenham Town Hospital

FATHER
12. Name Patrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Patton
15. Birthplace Ireland

16 (a) Informant Wife
(b) Address 1622 Holbrook St.

17 (a) Burial (b) Date thereof Feb 9 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) ..... (b) ..... Registrar
Date Received (Registrar)
FEB 6 1946
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2-46 19.., to 2-5- 1946, and that I last saw h.. alive on 2-5- 19 46.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions Prostatic Carcinoma (Latent)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Hetherington Sprague M.D.
Address Sydenham Hosp. Date signed 2-6-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Be careful of information entered.

G37165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G37165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Ballman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Frank Ballman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 28. 1873

8. AGE: Years 72 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob Bowles
13. Birthplace Md

MOTHER
14. Maiden Name Maria Huber
15. Birthplace Md

16 (a) Informant Miss Adele Ballman
(b) Address 3206 N. Calvert St.

17 (a) Burial (b) Date thereof Feb. 7/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Harry F. Tuttle
(b) Address 4101 E. Monument Ave.

(b) Feb 6 1946
(Date received by registrar)

Huntington Williams, Md
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8, 1942 to Feb 6, 1946 and that I last saw h[illegible] alive on Feb 6, 1946.

Immediate cause of death	Duration
Coronary artery occlusion	4 yrs.
Due to Arteriosclerosis	
Due to	
Other Conditions Arteriosclerotic brain disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H. Tillman M.D.
M. D.
Address 3035 St Paul St Date signed 2-7-46

X

G37166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

G37166
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Just came
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Ashtabula Ohio
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Lake Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bart DePascale

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 298-09-9523

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Marie DePascale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1909

8. AGE: Years 36 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER
12. Name: Vincent DePascale
13. Birthplace: Italy

MOTHER
14. Maiden Name: Mary Dadardi
15. Birthplace: Pa.

16 (a) Informant: Marie DePascale
(b) Address: 2605 LAKE Ave ASHTABOLA

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11-46 (month) (day) (year) OHIO
(c) Cemetery or crematory: Calvary
Location: Youngstown OHIO

18 (a) Funeral director: Frank Dellor Noel
(b) Address: 52 N. Hanley St.

FEB 6 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1945 to Feb 6 1946, and that I last saw him alive on 2-6 1946.

	Duration
Immediate cause of death: Malnutrition	4 mos
Due to: Ca Stomach	4 mos
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: Dec 5-45
Major findings of operation: Ca Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: C. J. Stedem Jr

Address: Mercy Hosp Date signed M. D. 2-6-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37167 Registered No.

Please write information asked for carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Agnes
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Kinsley Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bateman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Bateman
13. Birthplace Balt

MOTHER
14. Maiden Name Dorothy Schenk
15. Birthplace Balt

16 (a) Informant Raymond Bateman
(b) Address 33 Kinsley Rd

17 (a) Burial (b) Date thereof 2-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Frederick Ave

18 (a) Funeral director Robt E Brooks
(b) Address 1338 Hollins St

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 7 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1946, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1946 to 2-6 1946 and that I last saw h alive on 19

Immediate cause of death Atelectasis	Duration
Due to Prematurity 5½ mths	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. N. D'Elia Jr.

Address St Agnes Hosp Date signed 2/6/46
M. D.

X

G37168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162#

Registered No. G37168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 W. Cross Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Wallace

3 (b) If veteran, name war	3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widowed

6 (b) Name of husband or wife. Lydia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation B & O
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs C. McKay
(b) Address 4204 Barrington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd

18 (a) Funeral director Bernard Hahn
(b) Address 1000 S. Paca St

19 (a) FEB 7 1946 (Date rec'd by registrar) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1946 at 10:30 P

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Pres death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon Monoxide poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 5, 1946 M.
(b) Where did injury occur? 624 W. Cross St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Asphyxiation by illuminating gas

23. Signature Benedict Sbitarchi M.D.
Medical Examiner.
Date signed 2-6-46

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G37169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G37169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Appleby

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-46

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Baltimore Md
(Town, county, or state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name G. Appleby
13. Birthplace Balto.

MOTHER
14. Maiden Name P Santis
15. Birthplace Balto.

16 (a) Informant Appleby
(b) Address 939 W Baltimore St

17 (a) Burial (b) Date thereof Feb 7 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balair Rd

18 (a) Funeral director Joseph Kasmakas Sr
(b) Address 6 Cedar Park Pl

19 (a) FEB 7 1946 (b) Huntington Williams
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 1946, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1946 to 2-5 1946 and that I last saw h[illegible] alive on 2-5 1946.

Immediate cause of death	Duration
P. Prematurity (20 wks)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Comer, M.D.
Address Univ. Hosp Date signed 2-6-46 M. D.

correct age is especially important. Physicians: please write the

VS 150

G37170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G37170 Registered No.

Please answer every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1655 N. Bentalou St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1655 N. Bentalou St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Abr Siff

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband or wife Fanny Siff

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1874 [redacted]

8. AGE: Years 72 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Grocer

FATHER
12. Name Jacob Siff
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Jacob
15. Birthplace Russia

16 (a) Informant Miss Lillian Siff
(b) Address 1655 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Israel Cem.
Location Northern Ave

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto. St. (Huntington Williams, Mgr.)

19 (a) (Date rec'd by registrar) Registrar

FEB 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1946, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1945 to Feb 5 1946, and that I last saw him alive on Feb 4 1946.

Immediate cause of death	Duration
Arterio Sclerosis	
Myocarditis	
Cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kaden M. D.
Address 2306 Eutaw Pl. Date signed 2-6-46

X

G37171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37171 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Levitsky

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eli

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Isaac Schuster
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Balto Md & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E Balto St

19 (a) FEB 7 194 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1946, at 4:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1945 to 2/6 1946, and that I last saw h[illegible] alive on 2/6 1945

	Duration
Immediate cause of death Respiratory arrest due to Bronchopneumonia	3 days
Due to Cardiac Failure	2 days
Due to Arteriosclerotic Ht. disease	20 yrs
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation 1/16/46 - 1/31/46

Major findings of operation: Gangrene of foot Arteriosclerotic ostium of blood vessels

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Chernin M.D.
Address Sinai Hospital Date signed 2/6/46

VS 150

107

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G37172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3001 Fusby St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Fusby St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther M Cuddy

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color of race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 6 1904

8. AGE: Years 41 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph A Starr
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna Murray
15. Birthplace Balt Md

16 (a) Informant William A Cuddy
(b) Address 3001 Fusby St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director William Corkran
(b) Address 1217 E Cold St

19 (a) (Date rec'd by registrar) (b) Registrar for White Health Dept

FEB 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Feby 5 1946 and that I last saw h alive on Feby 6 1946

Immediate cause of death Carcinoma Splenic flexure Colon — Duration

Due to Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 1944

Major findings of operation Carcinoma Splenic flexure Colon

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F J Kirby M. D.
Address 10 E Northern Pkwy Date signed 2/6 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G37173 Registered No.

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 Ordway Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Ordway Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M Meyer

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1876

8. AGE: Years	Months	Days	If less than one day
69	8	21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Christian D Meyer
13. Birthplace Germany

MOTHER 14. Maiden Name Emma Collins
15. Birthplace Germany

16 (a) Informant Hannah Boylan
(b) Address 510 Ordway Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Tillson & Son
(b) Address 1219 Linden Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946, at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Jan 1946 to 6 Feb 1946, and that I last saw he alive on 5 Feb 1946

Immediate cause of death	Duration
Cerebral hemorrhage with Hemiplegia (left)	7 days
Due to Hypertensive cardiovascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E Taylor M.D.
Address 3962 Greenmount Ave. Date signed 6 Feb 1946

Huntington Williams, M.R.

G37174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1866

G37174 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Caithaum St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 Gorman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dela M. Bugglin (Buggles)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Louis L. Bugglin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1867

8. AGE: Years 79 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name William H Leonard

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name ——— Merson

15. Birthplace Baltimore Md.

16 (a) Informant Helen B. Bugglin

(b) Address 35 Gorman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 8/1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Harry H Amyscock

(b) Address 4204 Ridgewood Ave

19 (a) FEB 7 1946 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1946, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946, to 2/5 1946, and that I last saw her alive on 2/5 1946.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteriosclerosis	
Cerebral Vascular disease	
Due to	
Other Conditions Fracture left femur (Intertrochanteric)	

(Include pregnancy within 3 months of death)

Date of operation 1/17/46

Major findings of operation: Fracture Intertrochanteric left femur

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/2

(a) Accident, suicide, or homicide acc.

(b) Date of occurrence 1-8-46 at P. M

(c) Where did injury occur? 35 Gorman Ave. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no

(e) Means of injury Fell down stairway

23. Signature Bothy L. Jones M. D.

Address Woodlawn P.O. Md. Date signed 2/5/46

Howard J. Mercein, M. D. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

637175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 E. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ludwig Lindeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maria Lindeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1867

8. AGE: Years 78 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Germany (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Nicholas Lindeman

13. Birthplace Germany

MOTHER 14. Maiden Name Dorothy Rothaluske

15. Birthplace Germany

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2-9-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cemetery

Location Balto Maryland

18 (a) Funeral director Albert H. Nitch

(b) Address 1606 N Charles Street

19 (a) (Date received by Registrar) (b) Registrar

FEB 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946 at 10 1/2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1946 to Feb 6 1946 and that I last saw him alive on Feb 6 1946

Immediate cause of death: Right Cerebral Hemorrhage — Duration: 14 HOURS

Due to: ARTERIOSCLEROSIS

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel P. Asper Jr.

Address Johns Hopkins Date signed Feb 7, 46

Physician for Williams

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G37176 Registered No.

55c

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 So Linzh SO.
(c) Hospital or institution: So. Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore -25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 E. Andrew SO
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary SDankiewicz.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife Walter SDankiewicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/8 1889

8. AGE: Years	Months	Days	If less than one day
56	10	12	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Constantin Pfeiffer
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Kowalski
15. Birthplace Poland

16 (a) Informant Walter SDankiewicz
(b) Address 309 E. Andrew SO.

17 (a) Burial (b) Date thereof 2-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rozary
Location Baltimore County

18 (a) Funeral director George E Weber
(b) Address 705 S Pine St

19 (a) FEB 7 1946 (b)
(Date rec'd by Reg.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946, at 8 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Feb. 6 1946 and that I last saw her alive on Feb 6 1946

Immediate cause of death	Duration
Carcinoma of the	
Due to Thyroid Gland	
Due to Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address S. B. G. H. Date signed 2/6/46

Huntington Williams, M.D.

G37177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48 B

Registered No. G37177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 N. Linnard St.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 N. Linnard St.
(If rural give location)
(e) Citizen of foreign country? *** (Yes or No)
If yes, name country

3 (a) FULL NAME
Annie Heckert

3 (b) If veteran, name war ***
3 (c) Social Security Account No. ***

4. Sex Fe. Mle.
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Joseph Heckert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 28, 1881
8. AGE: Years 64 Months 10 Days 8 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Mark
13. Birthplace Baltimore

MOTHER
14. Maiden Name Brauer
15. Birthplace Baltimore

16 (a) Informant Charles V. Hill
(b) Address 624 N. Linnard ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) Date rec'd by Local Reg. FEB 7 1946 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946 at 2.30 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from Nov 2 1945 to Feb 5 1946 and that I last saw h.r alive on Nov 4 1946.

Immediate cause, of death	Duration
Carcinoma uteri	✓
Due to	
Due to Malignant Cachexia	✓
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury ✓
23. Signature John H. Graband
Address 2219 Eastern Ave Date signed 2/8/46

John H. Graband

correct age is especially important. Physicians: please write the

37178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-98052

X ✓ 8.3a

G37178 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Bittern Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Mariah Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Willie Jones (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29-1887

8. AGE: Years 58 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Boss Faison
13. Birthplace North Carolina

MOTHER
14. Maiden Name Julia ?
15. Birthplace North Carolina

16 (a) Informant: Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory
Location Raliegh, N. C.

18 (a) Funeral director Elder O. Wilson
(b) Address 1000 Druentley ave

19 Filed FEB 7 1946 (Date rec'd by registrar) Lucretia Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1946, to Feb. 6 1946 and that I last saw h er alive on Feb. 6 1946

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions: Enlarged Thyroid
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.

Address Baltimore City Hosp. Date signed 2-6-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

37179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G37179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 Myrtle Ave Dist.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Myrtle Ave (Rural route location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dave Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Chase City, Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jake Gregory
13. Birthplace Va

MOTHER
14. Maiden Name Emily Hardy
15. Birthplace Va

16 (a) Informant Mary Chee
(b) Address 414 Wyndcleave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Braddleyave

19 (a) FEB 7 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1946 3P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Collapse

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 2-3-46

G37180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939 Registered No. G37180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hosp 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1891

8. AGE: Years 54 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Maggie Chapman
(b) Address 13 N. Bond St.

17 (a) Burial (b) Date thereof 2/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brant Lane

19 (a) FEB 7 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Feb 1946, at 8 25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atherosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Kelbach M.D.
Medical Examiner
Date signed 5 Feb 46

VS 151

X

G37181

JL - 13781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G37181

Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 - 2 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Eldridge Albert Ridgely

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mamie Fay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1870

8. AGE: Years	Months	Days	If less than one day
75	1	20	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual Occupation Tinner (Retired)
11. Industry or business

FATHER
12. Name Evan Thomas Ridgely
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ellen Peddicord
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 7 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1946, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1921, to Feb. 6 1946, and that I last saw him alive on Feb. 6 1946.

Immediate cause of death Cerebrovasc. Acc. — Duration 2

Due to Arteriosclerosis

Due to

Other Conditions ASHD

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Parsons
Address B C H. Date signed 2/6/46

VS 150

83a

G37182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G37182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Dolfield Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Dolfield Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN HENRIETTA KNIGHT

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John J. Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1880

8. AGE: Years: 65 | Months: 2 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Eberhardt Wiessner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Regina Lessner
15. Birthplace: Germany

16 (a) Informant: Mr. John J. Knight
(b) Address: 3707 Dolfield Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 7 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945, to Feb 5 1946 and that I last saw h[illegible] alive on Feb 3 1946.

	Duration
Immediate cause of death: Carcinomatosis	
Due to: Carcinoma of Uterus	
Due to:	
Other Conditions: Coronary Heart Dis 13 Wks, Coronary Thrombosis (Include pregnancy within 3 months of death)	

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Edw. H. Hassman, M. D.
Address 4037 Falls Rd. Date signed 2/6/46

Physicians: please write the correct age is especially important. Fill in the causes of death clearly and legibly.

VS 150

637183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

637183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3024 Walbrook Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA W. SCHILDWACHTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Herman Schildwachter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1853

8. AGE: Years	Months	Days	If less than one day
92	10	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Klinger
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Krupp
15. Birthplace Germany

16 (a) Informant Mr. George C. Schildwachter
(b) Address 2808 Reisterstown Rd.

17 (a) Burial (b) Date thereof 2/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 7 1946 Washington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 5 1946, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1946, to Feb 2 1946 and that I last saw her alive on Feb 2 1946.

Immediate cause of death Chronic Myocarditis — Duration 20 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson M. D.
Address 305 W. North Ave Date signed Feb 6-46

VS 150

(OVER)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

Registered No. G37184

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 E. Center Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Herman Weasner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche Weasner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1895

8. AGE: Years	Months	Days	If less than one day
50	10	6	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William H. Weasner
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Smith
15. Birthplace

16 (a) Informant Records.
(b) Address South Balto. General Hosp.
17 (a) Burial (b) Date thereof 10-Feb-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Williamsport Penn.
18 (a) Funeral director Otto Funeral Home Inc.
(b) Address 46 44 York Rd.

FEB 7 1946 Huntington Williamsport
(Date rec'd by local registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946, at 6:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from January30 1946, to Feb. 6, 1946, and that I last saw him alive on Feb. 6, 1946.

Immediate cause of death	Duration
Pneumonia (contributing)	
of lung	
Due to Fracture of left hip	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold H. Weisner M. D.
Address S.B.G.H. Date signed 2-7-46

X

G37185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

Registered No. G37185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Ramsey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Ramsey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LYDIA C. SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Dead.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1870

8. AGE: Years 75 | Months 1 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Geo Stolzenbach

13. Birthplace Germany

MOTHER 14. Maiden name Wilhelmina Westrich

15. Birthplace Germany

16 (a) Informant Geo J Schmidt

(b) Address 1224 Elm Ridge Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Frederick Ave

18 (a) Funeral director Geo H. Kemdach

(b) Address 575 N. Lynd Street

19 (a) FEB 7 1946 (Date received by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6th 1946, at 4 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29th 1946, to Feb 6, 1946 and that I last saw him alive on Feb 5th 1946.

Immediate cause of death: Auricular fibrillation — Duration: 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry J. Kates

Address 617 Scott St. Date signed 2/7/46

Harry J. Kates X

VS 150

correct age is especially important. Physicians: please write the

G37186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G37186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 Riverside Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Riverside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Berryman.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colrd | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife William T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1893

8. AGE: Years: 52 | Months: 3 | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Laundry worker

11. Industry or business Laundry

FATHER
12. Name John Shaw
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Baltimore

16 (a) Informant Margaret Hill
(b) Address 1134 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director Howard L. Covington
(b) Address 21 W. 25th St

19 (Signature) Howard L. Covington (Title to be supplied by Registrar) Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1946, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Feb 5 1946, and that I last saw h alive on 2/5 1946

Immediate cause of death — Cerebral hemorrhage — Duration 1 mo.

Due to Hemiplegia — 1 mo.

Due to —

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 1279 William H Date signed 2/6/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

637187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 637187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3035 Shannon Dr.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3035 Shannon Dr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Langville

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Bromwell
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1874

8. AGE: Years	Months	Days	If less than one day
71	3	28	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Coal Dealer
11. Industry or business self —

FATHER
12. Name William J. Langville
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Willey
15. Birthplace Md.

16 (a) Informant Mrs Sarah Bromwell
(b) Address 3035 Shannon Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Ave

18 (a) Funeral director John F Kenny Inc
(b) Address 711 Light St.

19 (a) 2/12/46 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1946, at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1946 to Feb 6 1946 and that I last saw h alive on Feb 6 1946

Immediate cause of death	Duration
Coronary Thrombosis	2 hrs.
Due to Arterio sclerotic cardio-Vascular Disease	8
Due to Pneumonia Lobar Rt. Lung	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation Jan 7
Major findings of operation: Amputation Ptor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luther E. Little
Address 10 W. Madison St. M. D. Date signed 2-6-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Luther E. Little

G37188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

75c

G37188 Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write this information.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 N. Light St.
(c) Hospital or institution: Balto. Bella. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 Annabel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dyson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma Dyson

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 1-11-1915

8. AGE: Years 31 | Months | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Dyson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rickie Rembert
15. Birthplace Md.

16 (a) Informant Mrs. Emma Sykes
(b) Address 427 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory Loudon P/C
Location Frederick Ave

18 (a) Funeral director John F Henry Inc
(b) Address 715 Light St.

19 (a) 2/7/46 (Date filed by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1946, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1946, to 2-6 1946, and that I last saw him alive on 2-6 1946.

Immediate cause of death	Duration
Ruptured Appendix	
Due to Peritonitis Appendix	
Due to Appendicular Infarct	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-3

Major findings of operation: Ruptured Appendix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 1 E. B. St. Date signed 2/6/46

VS 150

G37188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G37189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Crain Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Leroy Harman

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-12-8624

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laura V Brannan

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) November 27, 1916

8. AGE: Years 29 | Months 2 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Laundries + Co

FATHER
12. Name Mort F Harman
13. Birthplace Germany

MOTHER
14. Maiden Name Amey Diemer
15. Birthplace Maryland

16 (a) Informant Mrs Laura V. Harman
(b) Address 110 Crain Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Glenburnie, Md

18 (a) Funeral director John F Denny Sue
(b) Address 1946 Light St.

FEB 7

19 (a) ... (Date rec'd by registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 19 46, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 19 46, to 2/6 19 46, and that I last saw h. alive on 2/5 19 46.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.
Address Md Gen'l Hospital Date signed 2/6/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1186a

G37190 Registered No.

Please write the cause of death clearly and legibly. The correct age is especially important. Physicians: please write the necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Madison
(c) Hospital or institution: Maryland General Hospital 14 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 McRoyal
(If rural give location)
(e) Citizen of foreign country? No 2 (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Laubheimer (MATILDA LAUBHEIMER)

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16 1875

8. AGE: Years 70 | Months 10 11 | Days 0 21 | (If less than one day) hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Louis Laubheimer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Hilda Frost
15. Birthplace Baltimore

16 (a) Informant Miss Lena Laubheimer (sister)
(b) Address 1408 McRoyal Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8 46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart & Howell Co.
(b) Address 1080 North Ave.

19 (a) FEB 7 1946 (Date rec'd by registrar) Hunting for Williams (Registrar) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6- 1946 at 12.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1946, to 2-6 1946, and that I last saw her alive on 2-6 1946

Immediate cause of death: Respiratory failure — Duration:

Due to: Probable cerebral accident

Due to:

Other Conditions: Concussion following fall
1+C V D
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 14/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-5-46 at 7' M
(c) Where did injury occur? Baltimore (City or town) Baltimore (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall on stairs

23. Signature Howard J. Mencken, M.D.
Address Md. General Hospital Date signed 2/6/46

VS 150

G37191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G37191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 S. Highland Ave.
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2555 Garrett Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J. Morrow

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Clarence H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	7	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Kircher
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Clarence R. Morrow
(b) Address 3310 Orlando Ave.

17 (a) Burial (b) Date thereof 2/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (d) FEB 1946 Date rec'd by registrar — Clarence Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1946, at 7.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to Feb 3 1946, and that I last saw h[illegible] alive on Feb 2 1946.

Immediate cause of death	Duration
Diabetes Mellitus	6-6-45
Hypertension O.V.R. Disease	
Impacted Fracture	Jan 30/46
Due to Renal Failure	
Due to None	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Eg Schumacher M. D.
Address 842 S Ellwood Ave Date signed 2-6-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37192

487398

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 567

G37192
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2944 S.W. 1 mt. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME a. Anita Graham

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ralph
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 10 - 23 - 02

8. AGE: Years	Months	Days	If less than one day
43	3	13	hr. min.

9. Birthplace N. Y. City
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name James Andreana
13. Birthplace Italy

MOTHER
14. Maiden Name ?. ?.
15. Birthplace Italy

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Miami, Fla.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place
FEB 7 1946 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1946, at 6 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1946, to Feb. 6 1946, and that I last saw her alive on Feb. 6 1946.

Immediate cause of death Broncho Pneumonia
Due to Post Operative
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 1/28/46
Major findings of operation: Mesenteritis - Ist. Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specific type of place)
(e) Means of injury

23. Signature Lew W. Chambers
Address Johns Hopkins Hosp. Date signed 2/6/46
Balto. Md. X

G37193 HEALTH DEPARTMENT—CITY OF BALTIMORE G37193

CERTIFICATE OF DEATH ✓ 131a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Broadway St., ✓ Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Albina Mackunis ✓

If U. S. Veteran specify WAR.....

(a) Residence: No. 98 Broadway St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

3a. If married, widowed, or divorced WIFE of (or) HUSBAND of Daniel Mackunis

6. DATE OF BIRTH (month, day, year) Mar. 15 1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
83	10	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 2/1/46

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Suwalki, Poland

FATHER

13. NAME John Tomaszewski

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Justine Herbst

16. BIRTHPLACE (city or town) (State or country) ??

17. INFORMANT Edith Mackunis

(Address) 98 Broadway

18. BURIAL, CREMATION, OR REMOVAL PA.

Place Mount Vernon Date Feb. 9 1946

19. UNDERTAKER Joseph Kasmakas Son

(Address) 602 Washington Blvd

20. FILED ... 19...

FEB 7 1946 Huntington White Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 7, 1946

22. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1946 to Feb 7, 1946

I last saw h.. alive on Feb 7, 1946 Death is said to have occurred on the date stated above, at 7:30 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
INTESTINAL OBSTRUCTION	2/1/46
Other contributory causes of importance: GENERALIZED ARTERIOSCLEROSIS	??
CHRONIC NEPHRITIS	??

Was an operation performed? No Date of —

For what disease or injury?

Name of operation —

What test confirmed diagnosis? CLINICAL Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify

(Signed) Joseph F. Djenga, M. D.

(Address) 209 E. Lexington St

OCCUPATION is very important. See instructions on back of certificate.

V.S. 8

1221

G37194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G37194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1139 Sargeant St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County V
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 Sargeant St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Mix

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William H. Mix Sr

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Nov 21. 1897

8. AGE: Years 48 | Months 2 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name George Mix

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Dora Reinisch

15. Birthplace Balto Md

16 (a) Informant William H. Mix Sr

(b) Address 1139 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9. 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location City

18 (a) Funeral director Wm. Mus. John Jr. Geisel & Son

(b) Address 801 W. Fayette St

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

FEB 7 1946

VS Form B

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Feb. 1946, at 1:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute pulmonary Edema

Due to Hypertensive Cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William F Neffner M.D.
Medical Examiner.

Date signed 6 Feb '46

X

G37195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G37195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Fleetwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. VIOLA M. SHEEHAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Joseph L. Sheehan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1 - 1898

8. AGE: Years	Months	Days	If less than one day
48	-	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Edward Bueckert
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine
15. Birthplace

16 (a) Informant Mrs. Joseph L. Sheehan
(b) Address 2908 Fleetwood Ave.

17 (a) Buried (b) Date thereof 2- -46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road.

19 (a) FEB 7 1946 Registrar
(Date rec'd by reg.)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1946, at 12:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Featherer M.D.
Medical Examiner.
Date signed Feb. 5 1946

637196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

637196 X 93c

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Arbutus v Md - Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. 2932 Louisiana Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William John Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	216-03-8277

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruth L. Jones
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 19, 1906

8. AGE: Years	Months	Days	If less than one day
39	7	18	..... hr. ..... min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Ass't. Office Mgr.
11. Industry or business Also-Gravure Co.

FATHER
12. Name John W. Jones
13. Birthplace Wales, England

MOTHER
14. Maiden Name Millie Ann Reynolds
15. Birthplace Va.

16 (a) Informant Mrs. Ruth L. Jones
(b) Address 2932 Louisiana Ave., Rosemont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 7 1946

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1946, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic C.V. Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature C. L. Pulaski Medical Examiner. M.D.
Date signed 2/7/46

G37197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37197 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.14
(b) Street address 433 Rosecroft Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Rosecroft Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Taylor

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Albert C. Taylor

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 30, 1876

8. AGE: Years: 69 | Months: 1 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Gottlieb Frey
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Eliza Ann Pardoe
15. Birthplace: Calvert Co., Md.

16 (a) Informant: Mrs. Mary L. Larrimer
(b) Address: Hanover, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md. Huntingtown, Md.

19 (a) (Date rec'd by registrar) FEB 7 1946 (b) Registrar

VS. 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1946, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to:

Other Conditions: Arteriosclerotic P.V. disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schrimbe M.D. (Medical Examiner.)
Date signed 2/7/46

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered G37198

G37198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y 4mo
(e) Length of stay in Baltimore (yrs., mos., or days) 72yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stella J. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: James Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1874

8. AGE: Years 72 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name John F Adams
13. Birthplace U-S-A.

MOTHER
14. Maiden Name Annie Tapper
15. Birthplace U S A

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b) (Date rec'd by registrar) Registrar.

FEB 7 1946 Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946, at 2.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Feb 6 1946, and that I last saw her alive on Feb 6 1946.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Hemorrhage	2 days
Due to	
Other Conditions Chr myocarditis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E. North Av Date signed 2/6 1946

1200 PK 83a

correct age is especially important: Physicians: please write the causes of death clearly and legibly.

G37199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G37199 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH: Franklin Square Hosp.
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun.
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Pontimie Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Cavanaugh.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Cavanaugh
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Cavanaugh Stella.
15. Birthplace Baltimore Md.

16 (a) Informant Gordon Cavanaugh
(b) Address 900 Pontimie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Shipley & Harbaugh
(b) Address 445 E. West St.

19 F 587 1946 (Date rec'd by registrar) waiting for Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1946 to 2/6 1946, and that I last saw h[illegible] alive on 2/6 1946 8:45 AM

Immediate cause of death Respiratory failure
Due to Intrauterine asphyxia.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Sq. Hosp. Date signed 2/7/46

G37200 BALTIMORE CITY HEALTH DEPARTMENT G37200

CERTIFICATE OF DEATH 93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Glover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Glover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christian J. Kumpf

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8801

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louisa Kumpf

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Apr 25. 1879

8. AGE: Years 66 | Months 10 | Days 11 | If less than one day ____hr. ____min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Mgr Meat Department

11. Industry or business Retail Trade

FATHER 12. Name Carl Kumpf

13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Rinehart

15. Birthplace Germany

16 (a) Informant Louisa Kumpf

(b) Address 27 N Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 9/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location City

18 (a) Funeral director Welsh Funeral Home

(b) Address 2005 Aliceanna St

19 (c) FEB 7 1946 (Date rec'd by registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6th 1946 at 10:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Warden M.D. Medical Examiner.

Date signed 2-6-46

VS 151

G37201 Kysarik

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G37201
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 938 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 938 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? Ger (Yes or No)
If yes, name country

3 (a) FULL NAME Magdalena Kral

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph F. Kral

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1868

8. AGE: Years 77 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Bohemia Czechoslovakia
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joseph Smrha
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not Known
15. Birthplace Bohemia

16 (a) Informant Frank J. Kral
(b) Address 938 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Crockett
(b) Address 900 W. Chester St 5

19 (a) (b)

Filed FEB 7 1946 Huntington White, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946 at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Feb 5 1946
and that I last saw h[illegible] alive on Feb 5 1946

Immediate cause of death Hypostatic Pneumonia — Interval 2/5/46

Due to Cremoma of Pancreas — 9/1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rylands
Address 801 N. Kenwood Ave Date signed 2/7/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G37202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G37202 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 181
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 W. Lexington St - 1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robt dixon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/45

8. AGE: Years	Months	Days	If less than one day
3 mon.	1	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Albert Dixon
13. Birthplace Md.

MOTHER 14. Maiden Name Delores Howard
15. Birthplace Md.

16 (a) Informant Delores Howard
(b) Address 1101 Lamens St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 7 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 to Feb 3 1946, and that I last saw him alive on Feb 3 1946.

Immediate cause of death	Duration
Resp. failure	
Due to Bilateral Bronchial pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard O Shaw M.D.
Address Univ. Hosp Date signed 2/3/46

VS 150

5283

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

G37203

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Punctuation is unnecessary.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Lauriens St. 17 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ferrell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1 day			hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Evelyn Ferrell
15. Birthplace 815 W. Lafayette Ave Balto Md

16 (a) Informant Evelyn Ferrell
(b) Address 815 W Lafayette Ave Balto Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 7 1946 (Date rec'd by registrar) (Name of City or County Registrar)

5252

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1946 to Feb 3 1946, and that I last saw him alive on Feb 3 1946.

Immediate cause of death	Duration
Resp. Failure	
Due to Cerebral Hemorrhage at birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard A Hoon M. D.
Address Univ. Hosp Date signed 2/8/46

X

G37204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G37204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Foster or Edward Forster

3 (b) If veteran, name war: None.

3 (c) Social Security Account No. 213-07-7527

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Blanche

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 16, 1896

8. AGE: Years 49 | Months 6 5 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Foster
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude ?
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Weydert Chapel
(b) Address 315 N. Paca St.

19 (a) Filed FEB 7 1946 by registrar Hunting on Notebook, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1946, at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1946 to Feb. 4 1946, and that I last saw him alive on Feb. 4 1946.

Immediate cause of death	Duration
Obstruction of common bile duct by gall stone	
Due to	
Due to	
Other Conditions Cirrhosis of liver, Bile nephrosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. P. Jervigon M. D.
Address Baltimore City Hall Date signed 2-5-46

X

correct age is especially important. Physicians: please write the

G37205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 95c

G37205 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 Dillon St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry J. Rosen. (ROSSEN)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-8570

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Alice S. Rosen.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 3 1894

8. AGE Years	Months	Days	If less than one day
51	11	1	hr. min.

9. Birthplace Rochester New York
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Decorator

FATHER 12. Name Morris Rosen.
13. Birthplace Rochester, New York.

MOTHER 14. Maiden Name Sarah Cass.
15. Birthplace U.S.

16 (a) Informant Mrs. Alice S. Rosen.
(b) Address 3910 Dillon Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Essex, Md.

18 (a) Funeral director Phyllis Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) FEB 7 1946 (b) (Date rec'd by registrar) Huntington Wilson Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1946 at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion, marked Cardiac Hypertrophy

Due to General Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 2-7-46

G37206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 8/a

G37206

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER.
(c) Hospital or institution:
St JOSEPH'S HOSP. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 S. LEHIGH. ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Naomi Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-8-20

8. AGE: Years 25 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace BALTO MD.
(Town, county, and state)

10. Usual Occupation UNEMPLOYED.

11. Industry or business

FATHER
12. Name THOMAS SMITH
13. Birthplace BALTO MD

MOTHER
14. Maiden Name ESTELLA SMITH
15. Birthplace BALTO, MD.

16 (a) Informant Mrs Stella Smyth
(b) Address 522 Lehigh St (24)

17 (a) Burial (b) Date thereof 2-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location Frederick Rd Balto Md

18 (a) Funeral director Wilkes, Schilling
(b) Address 3914 S Hanover St (25)

19 (a) 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 6 1946 at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1946, to 2-6 1946, and that I last saw her alive on 2-6 1946.

Immediate cause of death	Duration
MENINGITIS PNEUMOCOCCUS	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Wilkes M. D.
Address St Joseph Hosp Date signed 2-6-46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G37207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G37207 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Lemon Monument Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days). 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Dantry Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnny Leroy Caraway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 - 46

8. AGE: Years | Months | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Accie Leroy Caraway
13. Birthplace N. C. Atkinson

MOTHER 14. Maiden Name Premmer Masonis
15. Birthplace N. C.

16 (a) Informant Premmer Caraway
(b) Address 925 Dantry Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) Feb (day) 46 (year)
(c) Cemetery or crematory Holy Cross
Location Gor. Ritchie Highway

18 (a) Funeral director Milton Schilansky
(b) Address 3914 W. Hamburg St.

19 (a) FEB 7 1946 (Date rec'd by registrar) (b) Arlington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6, 1946, at 2 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 19 46, to Feb 6 19 46, and that I last saw him alive on Feb 5 19 46.

Immediate cause of death Congenital Heart Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Congenital Heart Failure

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Forrest M.D.

Address 925 Dantry Court Date signed 2-6-46

G37208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37208
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Oakland
(c) Hospital or institution: West Baltimore Gen Hosp 2-7-46

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Md
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 455 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannye Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jack D. Murphy (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 23 1888

8. AGE: Years 57 | Months 3 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Siegel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Blum
15. Birthplace Balto Md

16 (a) Informant Mrs. J. D. Murphy
(b) Address 4655 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9 1946 (month) (day) (year)
(c) Cemetery or crematory Har Sinai Cemetery
Location Erdman Ave

18 (a) Funeral director J. Hrezo & Co
(b) Address 2402 Reisterstown Rd

19 (a) (b) (c)

(Signature of registrar)

1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/46 1946 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1945 to Feb 6 1946; and that I last saw h.c.r alive on Feb 6 1946.

Immediate cause of death: Resp. Failure — Duration

Due to Intracranial Hemorrhage

Due to and Cerebral Sclerosis

Due to Arteriosclerotic C.V. D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Leo A. Stael M.D.
Address West Balto Gen Hosp. Date signed 2/7/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

374945
G37209

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G37209

CERTIFICATE OF DEATH 54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Abingdon.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-36

8. AGE: Years 9 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. Hopkins
13. Birthplace Virginia

MOTHER 14. Maiden Name Isabelle Thacker
15. Birthplace Virginia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7/46 (month) (day) (year)

(c) Cemetery or crematory
Location Abingdon, Va

18 (a) Funeral director Mitchell Sons.
(b) Address 1900 Eutaw Place,

FEB 8 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1946 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1946 to Feb 7 1946 and that I last saw him alive on Feb 7 1946

Immediate cause of death Brain tumor — Edema of brain

Duration

Due to Brain tumor — Edema of brain — Metastasis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/6/46

Major findings of operation Brain tumor — Edema of brain

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth W. Saunders
Address Johns Hopkins Hosp. Date signed 2/7/46
Baltimore, Md.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G37210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 W. University Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 W. University Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. Frances Crowther

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 26th 1859

8. AGE: Years 86 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joshua Crowther
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Altha Redden
15. Birthplace Md

16 (a) Informant Mrs 20th Barnett Wright
(b) Address 806 W. University Pkwy

17 (a) Burial (Burial, cremation, removal)
(b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

FEB 9 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7th 1946, at 6 30/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1946 to Feb 6 1946 and that I last saw her alive on Feb 6 1946.

Immediate cause of death	Duration
Cardio-Renal Failure	
Due to Cerebral hemorrhage	
Due to Generalized arteriosclerosis; Cardio-vascular disease	
Other Conditions Senile dementia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurland Edward Day M.D.

Address 4-E-33rd St Date signed Feb 7 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G37211 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: Sarah Boltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Bevans Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Henry Allerdice

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: 216-01-1136

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8/12/1897

8. AGE: Years 48 49 | Months 10 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Port Maria B.W.I. (town, county, and state)

10. Usual Occupation L

11. Industry or business .....

FATHER 12. Name Isreil Alldrie

13. Birthplace B.W.I.

MOTHER 14. Maiden Name Helen ?

15. Birthplace B.W.I.

16 (a) Informant Rebecca Alldrie

(b) Address 912 Bevans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Q & Co Md

18 (a) Funeral director Daniel L Brown

(b) Address 1842 Montgomery St

19 (a) FEB 8 1946 (Date rec'd by registrar) (b) Huntington Willi... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3, 1946, at 5 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, massive

Due to hypertensive cardio-vascular disease

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed Feb 4, 1946.

G37212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G37212
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town RURAL - LONG GREEN
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH SCHROEDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1862

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ? HERMIT

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant MR NOAH OFFUTT, (LAWYER)
(b) Address COCKEYSVILLE, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Moreland Park Cem.
Location Parkville, Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

19 (a) (Date rec'd by registrar) (b)

FEB 8 1946

Hunting for Hermit

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6-46 19 , at 3 39 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1946, to 2-6 1946 and that I last saw h. alive on 2-6 1946

Immediate cause of death: Uremia — Duration

Due to Generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hayle Edmunds M.D.
Address U.M.H. Date signed 2-6-46

X

G37213

JL - 99023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G37213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16hrs. 35m
(e) Length of stay in Baltimore (yrs., mos., or days) LIFT

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTO. 10
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3249 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman John Schnitzer or Schnitzker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1893

8. AGE: Years 52 | Months 3 2 | Days 19 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation STATIONARY ENGINEER

11. Industry or business SPARROWS POINT

FATHER
12. Name Frederick SCHNITZKER
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Manning
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O' Donnell Str. Ext.

18 (a) Funeral director Lilly & Custer Sons
(b) Address 403 S. Wolfe Street Huntington Maryland

19 (a) (b) Date rec'd by reg. Registrar

FEB 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1946, at 8.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4, 1946 to Feb. 4 1946 and that I last saw him alive on Feb. 4 1946

Immediate cause of death: Shock, postop. — Duration: Hrs.

Due to Acute intestinal obstruction — 10 days

Due to hernia, strangulated — 2

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-4-46

Major findings of operation: as above

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address Balto City Hosp's Date signed 2-5-46

X

correct age is especially important. Physicians: please write the

637414
CWK-96447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

637214
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 22- 6- 5-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Elliott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Marie Kowalevicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry Kowalevicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1-1923

8. AGE: Years	Months	Days	If less than one day
22	6	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Martin Wiatrowski
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances Siewierski
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11, '46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson Street.

19 (a) (b)
(Date rec'd by reg'l dept.) Registrar

FEB 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 19 46 at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 19 45 to Feb. 6 19 46, and that I last saw her alive on Feb. 6 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 2/6/46

Huntington Williams, M.D.

G37215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. G37215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Monty. Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Woodrow Moore Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1945

8. AGE: Years	Months	Days	If less than one day
	3	26	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Woodrow W. Moore Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Isabelle Gray
15. Birthplace Md.

16 (a) Informant Woodrow Moore
(b) Address Ellicott City Md.

17 (a) Burial (b) Date thereof 2-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director F. P. Dysinbothom
(b) Address Ellicott City Md

19 (a) FEB 8 1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1946, at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1946, to Feb 7 1946, and that I last saw him alive on Feb 7 1946.

Immediate cause of death	Duration
By Lard Stenosis	
Due to Malnutrition	
Due to Post Operative Stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan 25, 1946
Major findings of operation: By Lard Stenosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Miles Drake M. D.
Address Univ Hosp. Date signed 2-7-46.

Miles Drake X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G37216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4419 Frederick Av.
(c) Hospital or institution:
25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4419 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? Usa (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine R. Hooper.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1864

8. AGE: Years 81 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business At Home.

FATHER 12. Name George W. Hooper

13. Birthplace Cambridge Md.

MOTHER 14. Maiden Name Mary Jennings

15. Birthplace Ireland

16 (a) Informant Miss Sadie Hooper

(b) Address 4419 Frederick Ave.

17 (a) ~~Burial~~ (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Fahey & Sons

(b) Address 1827 W. North Ave.

19 (a) FEB 8 1946 (Registered by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1946, at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to Feb. 6 1946 and that I last saw h-- alive on Feb. 5 1946

Immediate cause of death	Duration
Chronic Valvular Heart Disease (Mitral Insufficiency)	1935
Due to Chronic Interstitial Nephritis	1938
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.

Address 1663 W North Ave Date signed 2/6/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37217
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Showers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

Johns Hopkins Medical Sch FEB 8 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) FEB 8 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1946, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed Jan 27 1946.

VS 151

15284

Orb 25-1899

G37218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G37218 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Michael Beckmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/25/99

8. AGE: Years 47 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace New Orleans La.
(City, county, and state)

10. Usual Occupation Watchman

11. Industry or business Gibbs Packing Co.

FATHER
12. Name Theodore Beckmann
13. Birthplace New Orleans La

MOTHER
14. Maiden Name Rosa Georges
15. Birthplace New Orleans La

16 (a) Informant Joseph L. Beckmann
(b) Address 1848 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9th 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Rood
Location Belair Road

18 (a) Funeral director Lee & Leach
(b) Address 1201-03 N. Patterson Park Ave.

19 (a) Filed [illegible] 1946 (b) Registrar

FEB

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1946, at 8:45 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2/46 1946, to 2/7 1946, and that I last saw h[illegible] alive on 2/7 1946

Immediate cause of death	Duration
Cerebro-meningitis, [illegible]	
Due to Uremia	
Due to Complications, cerebro spinal meningitis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley

Address 1400 N. Calvert Date signed 2/8/46

X

G37219 BALTIMORE CITY HEALTH DEPARTMENT G37219

CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 3802 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Morhiser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minna Kling Morhiser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1887

8. AGE: Years 58 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Structural Bridgeman

FATHER
12. Name John M. Morhiser
13. Birthplace Md

MOTHER
14. Maiden Name Addie Beck
15. Birthplace Md

16 (a) Informant Mrs. Minna Morhiser
(b) Address 3802 Harlem ave

17 (a) Burial (b) Date thereof Feb. 9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md

18 (a) Funeral director Harry H. Dautrich
(b) Address 4101 Edmondson Ave

19 (a) (b) Estimator for Williams
(Date rec'd by registrar) Registrar

FEB 8 1946
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MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1946, at 9:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions Arteriosclerotic C.V disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sulinski M.D.
Medical Examiner.
Date signed 2/7/46

37220 G37220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 S. Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Paca St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kostantas Fred Zebuth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ursula Zebuth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1883

8. AGE: Years 62 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Lithuanian (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Clothing

FATHER: 12. Name ? Zebuth

13. Birthplace Lithuanian

MOTHER: 14. Maiden Name ?

15. Birthplace Lithuanian

16 (a) Informant Mr. Edward Zebuth

(b) Address 620 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4430 Belair Road

18 (a) Funeral director John J. Greblunckas Jr

(b) Address 423 S. Paca St.

FEB 8 1946 (Date rec'd by registrar) Huntington Williams Inc (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Feb 6, 1946, and that I last saw him alive on Feb 5, 1946

Immediate cause of death Pulmonary edema, | Duration About 2 years

Due to Left ventricular failure

Due to Hypertension and arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. R. Lampke M. D.

Address 642 Wash. Blvd Date signed 2-7-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637221 Acad

637221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V160C

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 28, 1946

8. AGE: Years | Months | Days | If less than one day: 1 hr. 10 min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Henry Brooks
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Willie Mae Hood
15. Birthplace: South Carolina

16 (a) Informant: Hospital Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical Schoo FEB 8 1946

18 (a) Funeral director: Commissioner of Health
(b) Address

19 FEB 8 1946 (Date rec'd by registrar) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1946 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1946, to Jan 28 1946 and that I last saw h alive on Jan 28 1946

Immediate cause of death: asphyxia neonatorum, atelectasis — Duration

Due to: intra urterine ataxia premature separation of placenta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Gilbert J. Vosburgh M. D.
Address: Johns Hopkins Hospital Date signed 1-30-46

3266

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37222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37222
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Use necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1944 W. North Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1944 W. North Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carrie L. Schelle

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife -----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1863

8. AGE: Years	Months	Days	If less than one day
82	6	1	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frederick Schelle
13. Birthplace Germany

MOTHER
14. Maiden Name Ellen Lahey
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Nannie L. Ehlen
(b) Address 1944 W. North Ave.,

17 (a) Burial (b) Date thereof 2-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

FEB 8 1946 Huntington Williams MD
(Date rec'd by local registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5/46 19 4-35 P.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Feb 5/46 19
and that I last saw h-- alive on Feb 5 1946

Immediate cause of death	Duration
Acute dilitation Heart	Duration
Due to Arter Sclerosis	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury

23. Signature Henry C Houck MD
Address 1711 W North Ave Date signed 2/7/46

VS 150

G37223 G37223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Certificate No. G37223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3446 Dolfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3446 Dolfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Tumminello

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Carmello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Porpora
13. Birthplace Italy

MOTHER
14. Maiden Name Katie Battaglia
15. Birthplace Italy

16 (a) Informant Mrs Katie Tumminello
(b) Address 3446 Dolfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb - 8 - 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Tarasi Inc
(b) Address 20 E Fleet Street Ave

19 (a) FEB 9 1946 (Date received by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1946 at 340 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3, 1946 to Feb. 6, 1946 and that I last saw her alive on Feb. 6, 1946

Immediate cause of death Arteriosclerotic Cardio-Vascular Renal disease C decompensation — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sa Tumminello M.D.
Address 711 Medical Arts Bldg Date signed 2/8/46

Carlton Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D.O.A. G37224

Medical Examiner's Case.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 107

G37224 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. County
(c) City or town St. Margarets.
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. #2. Box - 427.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Julia A. Brown. ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1942

8. AGE: Years	Months	Days	If less than one day
	4.		hr. min.

9. Birthplace St. Margretts, A.A.Co. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Wilbert Brown
13. Birthplace Arnold, Md.

MOTHER 14. Maiden Name Heildine Henson
15. Birthplace St Margretts

16 (a) Informant Rennda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10 1946 (month) (day) (year)
(c) Cemetery or crematory Henson Cemetery
Location St. Margretts. Md.
18 (a) Funeral director J.B. Johnson
(b) Address Annapolis, Md.
19 (a) FEB 10 1946 (Date rec'd by registrar) Killmon, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6th 1946, at 7:15 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1946 to Feb 6 1946, and that I last saw h[illegible] alive on Feb 6 1946

Immediate cause of death	Duration
Pulm. congestion	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert Gremmel
Address Johns Hopkins Date signed Feb 6 1946

Howard J. Clemens, M. D. ✓

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G37225 BALTIMORE CITY HEALTH DEPARTMENT G37225

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida. Mullin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1889

8. AGE: Years 56 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace S.C. Georgia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Robert Robbins
13. Birthplace Georgia

MOTHER
14. Maiden Name Rhoda Lawrence
15. Birthplace Georgia

16 (a) Informant Rhoda McLain
(b) Address 1619 N. Gilmor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) FEB 8 (b) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerosis cardio vascular Disease

Due to

Other Conditions Pulmonary Edema, marked

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed 2-7-46

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G37226
CWK-98612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 G37226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 35- 3- 29

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 W. Saratoga Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8-1910

8. AGE: Years 35 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Spriggs
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 8 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1946, at 9:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1946, to Feb. 7 1946, and that I last saw him alive on Feb. 7 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 2/8/46

Turnington for Mr.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

No. G37227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 N. Vincent St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Spencer.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry Spencer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1899.

8. AGE: Years 46 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Mary Jackson.
15. Birthplace Va.

16 (a) Informant Clarence Spencer (redacted)
(b) Address 28 N. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 8 (Date rec'd by registrar) (b) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 19 46, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 19 45 to 2/4 19 46
and that I last saw her alive on 2/4 19 46.

Immediate cause of death Carcinoma of the uterus — Duration 8 mos.

Due to

Due to

Other Conditions Congestive Hypostasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Beckham M.D.
Address 426 N. Gilmor Date signed 2/6/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

37228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

G37228 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3724 Northern Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel S. Funk

3 (b) If veteran, name war	3 (c) Social Security Account No.

4 Sex	5 Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nettie A. Funk
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 10/16/1877

8. AGE: Years	Months	Days	If less than one day
68 69	3	19	hr. min.

9. Birthplace Md Allegany Co, Penna. (town, county, and state)
10. Usual Occupation Retired
11. Industry or business Balto Transit Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace " "

16 (a) Informant Nettie A. Funk
(b) Address 3724 Northern Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Laedlein Funeral Home
(b) Address 7401 Belair Road

FEB 8 1946 (Date rec'd by Registrar) (b) Huntington Williams III Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1946, at 1030 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1946 to 2/7 1946 and that I last saw h 14 alive on 2/7 1946

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Pulmonary Embolism	
Due to	
Other Conditions Hydronephrosis.	

(Include pregnancy within 3 months of death)
Date of operation 1/14/46
Major findings of operation: Cancer Prostate Hypertrophy
of autopsy: Pulmonary Embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J Riley
Address 1400 N. Caroline Date signed 2/3/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37223 ✓ G37223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 (1) Registered No. 15 64

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F. Love

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: ELIZABETH LOVE
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 79 | Months — | Days — | If less than one day hr. min.

9. Birthplace VA. (Town, county, and state)

10. Usual Occupation PRINTER

11. Industry or business

FATHER
12. Name RICHARD LOVE
13. Birthplace MD.

MOTHER
14. Maiden Name — HARVEY
15. Birthplace VA.

16 (a) Informant MR. BENNET LOVE
(b) Address 1605 N. BOND ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-46 (month) (day) (year)
(c) Cemetery or crematory ST. MARY'S
Location GOVAN'S

18 (a) Funeral director MARY M. WIEDEFELD
(b) Address 501 E. 32ND ST.

19 (a) FEB 8 1946 (Date rec'd by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1946, at 5 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured pelvis
Retroperitoneal hemorrhage
Contusion Rt kidney
Fractured Rt fibula
Other Conditions Lobular pneumonia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/1/46 at 9-7 3 A. M.
(b) Where did injury occur? Harford Rd & Homestead Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Benedict Shtarelick M.D. Medical Examiner.
Date signed 2-6-46

G37230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G37230 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Perkins - Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 No Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mc Clelland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/46

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name [redacted] James
13. Birthplace Md

MOTHER 14. Maiden Name Mary
15. Birthplace Md

16 (a) Informant Father
(b) Address 3811 No Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 8 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1946, at 9:27 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1946 to 2/7 1946, and that I last saw h[illegible] alive on 2/7 1946.

Immediate cause of death	Duration
Abnormal pelvis Hydrocephalus & bladder	
Due to 2. Cleft of	
B. Central Nervous System	
Due to 4. Congenital heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. D'Eliatr M. D.
Address St Agnes Hosp Date signed 2/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G37231 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joann Kelso Richardson

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	

6 (b) Name of husband or wife Maurice A. Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1896

8. AGE: Years	Months	Days	If less than one day
49	4	0	hr. min.

9. Birthplace Vevay, Indiana (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Everette Kelso
13. Birthplace Ind.

MOTHER
14. Maiden Name Edith Luck
15. Birthplace Ind.

16 (a) Informant Mr. Maurice A. Richardson
(b) Address 2924 St. Paul St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory
Location Indianapolis, Ind.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date) (b) Registered by FEB 8 1946 Practitioner for Wm. Bernard M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1946, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 19[illegible], to 2/7 1946, and that I last saw h[illegible] alive on 2/7 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Generalized Carcinomatosis following long standing	
Due to Carcinoma Left Breast	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morton E. Grobel M.D.
Address Md. Gen. Hospital Date signed 2/7/46

X

637232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G37232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Rogers Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Rogers Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FRANCIS SELLES, Sr.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 705-05-3541

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Josephine Selles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1878

8. AGE: Years 69 | Months 11 | Days 27 | If less than one day: 24 hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: B. & O. R.R. Ret. 1 yr.

11. Industry or business: Riverside shops

FATHER
12. Name: Frederick C. Selle
13. Birthplace: Germany

MOTHER
14. Maiden Name: Eva Gensler
15. Birthplace: Germany

16 (a) Informant: Mr. Charles Selle, Jr.-
(b) Address: 3111 Rogers Avenue

17 (a) Burail (Burial, cremation, or removal) (b) Date thereof 2-9-46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b) Huntington Wilkinson, M.D.
(Date rec'd by registrar) FEB 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1946, 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 44 1946 to Feb 7 1946.
and that I last saw alive on Feb 7 1946.

Immediate cause of death: Lymphic Sarcoma — Duration 2 yr.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Samuel V. Caine M. D.

Address 611 Pinehurst Rd. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Toomey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4 Sex	5 Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife A. Dixie Toomey
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 9, 1886

8. AGE: Years	Months	Days	If less than one day
59	8	27	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Daniel T. Toomey
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna R. McFaul
15. Birthplace Maryland.

16 (a) Informant Mrs. A. Dixie Toomey
(b) Address 415 Belvedere Ave, Balt. 12.

17 (a) Burial (b) Date thereof 2-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant
Location Hampstead, Carroll Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Glen Burnie, Md.

19 (a) FEB 8 1946 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 6 1946 at 1230 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to 6 Feb 1946, and that I last saw him alive on 5 Feb 1946.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular disease	
Due to	
Due to	
Other Conditions Bronchial Asthma	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William G. Stefanek
Address 5306 Roland Ave Date signed 6 Feb 46

VS 150

correct age is especially important. Physicians: please write the

637234 Dr. Sawyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. 637234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4417 Mannasota Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4417 Mannasota Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard L. Maher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Maher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1874

8. AGE: Years	Months	Days	If less than one day
71	9	12	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B. & O. R.R.

FATHER
12. Name Edward Maher
13. Birthplace ?

MOTHER
14. Maiden Name Honora ?
15. Birthplace ?

16 (a) Informant Mrs. Mary Maher
(b) Address 4417 Mannasota Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) FEB 8 1946 (Date rec'd by Registrar) (b) Filing or Millington

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1945 to Feb 7 1946 and that I last saw him alive on Feb. 6 1946

Immediate cause of death	Duration
acute Coronary Occlusion	2 weeks
Due to Generalized arteriosclerosis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George Dennis
Address 4808 Harford Rd Date signed 2/8/46 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Stevens
Extension Edison
637235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 637235

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3410 Chesterfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Chesterfield
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Roycroft

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-0071

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elizabeth M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7 - 1886

8. AGE: Years	Months	Days	If less than one day
60	1	-	hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)
10. Usual Occupation Crown, cork, + Seal.
11. Industry or Business

FATHER
12. Name Joseph Roycroft
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Blume
15. Birthplace Md.

16 (a) Informant Mrs. George Goebel
(b) Address 3416 Chesterfield
17 (a) Burial (b) Date thereof 2-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.
18 (a) Funeral director Leopard J. Rusk
(b) Address 5305 Harford Rd.
19 FEB 8 1946 (by) for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1946 to Feb 7 1946 and that I last saw him alive on Feb 7 1946.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. B. Stevens M.D.
Address 3408 Eutaw Date signed 2/7/46

X

G37236 rbold
1706 Harford.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G37236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Southern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Carrie Meeks Davidson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife: Harry Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1873

8. AGE: Years	Months	Days	If less than one day
72	2	21	hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation: at home
11. Industry or business

FATHER
12. Name: John Wesley Meeks
13. Birthplace: Md.

MOTHER
14. Maiden Name: Annie C. Eggar
15. Birthplace: Md.

16 (a) Informant
(b) Address 3005 Southern Avenue 9140

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14

19 (a) FEB 8 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946, at 8:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1942 to Feb. 6 1946, and that I last saw her alive on Feb 6 1946.

Immediate cause of death Coronary Thrombosis — Duration 1/2 hr

Due to Chronic myocarditis with myocardial degeneration

Due to Arteriosclerosis Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. V. Harbold M.D.
Address 1706 Harford Road Date signed 2/7/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37237 Dr. Lolly
3549 Edmonsdon Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G37237

Type or print clearly in ink. Do not write over printed letters. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 West Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits; write RURAL and give town)
(d) Street No. 3500 West Franklin Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Cotton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William E. Cotton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1870

8. AGE: Years	Months	Days	If less than one day
75	9	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Schweitzer
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. John Cotton
(b) Address 3407 White Avenue-

17 (a) Burial (b) Date thereof 2/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) FEB 9 1946 (b) Martin Lee Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946 at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Feb 6 1946 and that I last saw her alive on Feb 6 1946

Immediate cause of death Carcinoma of Breast — Duration 2 months
Colon

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. A. Lacy
Address 3517 Edmondson Date signed Feb 9 1946

X

G37238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. G37238

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Sydenham Hosp. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Kerr

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/7/40

8. AGE: Years	Months	Days	If less than one day
6	0	0	hr. min.

9. Birthplace Middletown, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Ralph Wilmer Kerr
13. Birthplace Middletown, Md.

MOTHER
14. Maiden Name Jessie Huffer
15. Birthplace Middletown, Md.

16 (a) Informant Father
(b) Address 1012 Paca St.

17 (a) Burial (b) Date thereof 2/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem
Location Wash. Blvd

18 (a) Funeral director Joseph Kasinskas Inc
(b) Address 604 Wash. Blvd

19 FEB 8 1946 (Date rec'd by registrar) (b) Huntington-Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1946, at 5:23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1946 to Feb 7 1946, and that I last saw h[illegible] alive on Feb. 7 1946.

Immediate cause of death Ludwig's Angina	Duration
Due to Diphtheritic Impaction	
Due to Pharyngeo-Tracheo diphtheria	
Other Conditions Pneumonia and pulmonary atelectasis	

(Include pregnancy within 3 months of death)
Date of operation 2/3/46 - Tracheotomy
Major findings of operation: Diphtheritic membrane of larynx & trachea
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin A. Sprague M. D.
Address Sydenham Hosp. Date signed 2-7-46

VS 150

G37239 ✓ G37239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Penalty for making false statements in connection therewith applies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4214 Evans Chapple Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write Co. and give town)
(d) Street No. 4214 Evans Chapple Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Moten Shelton

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife Charlotte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
78 77			hr. min.

9. Birthplace Richmond, Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jacob Shelton
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Fannie E. Seay
(b) Address 4214 Evans Chapple Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/46 (month) (day) (year)
(c) Cemetery or crematory Harpers Ferry
Location Wyt Va.

18 (a) Funeral director Geo. H. Kelson
(b) Address 430 3 Preston

19 (a) FEB 8 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1946, to Feb 5 1946, and that I last saw h[illegible] alive on Feb 5 1946.

Immediate cause of death	Duration
Sepsis	
Bronchopneumonia Jan 30	1946
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 35 N Jefferson Date signed

VS 150

G37240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G37240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2431 E. Fayette St.
(c) Hospital or institution:

6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE MAY PETERS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1870

8. AGE: Years	Months	Days	If less than one day
75 76 yrs.	10	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Peters
13. Birthplace Germany

MOTHER
14. Maiden Name Annie E. Cole
15. Birthplace Westminster, Md.

16 (a) Informant Joseph M. Brooks
(b) Address 2431 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Roland Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison St.

19 (a) 1946 (Date received by registrar) (b) Huntingtor Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr. 6th 1946 at 11½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6th 1946 to 19..., and that I last saw h[illegible] alive on Feb. 6th 1946.

Immediate cause of death Cerebral hemorrhage,
Due to Arteriosclerosis
Due to
Other Conditions Paralysis after a stroke years ago
(Include pregnancy within 3 months of death)

Duration
Unknown to me

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clara Tranzott M. D.
Address Lombard & Pine Date signed 2-8-46

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The information furnished should be accurately supplied. The

G37241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

Registered No. G37241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 N. Bradford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 N. Bradford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA PETRAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Wingle

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1872

8. AGE: Years 73 77 yrs. | Months 6 | Days | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Tailoring

11. Industry or business Schloss Brothers

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Josephine Leverton
(b) Address 801 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) 1946 (Date rec'd by registrar) (b) Huntingtown Williamsburg Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Feb 1946, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Feb 1946 to 7 Feb 1946, and that I last saw h[illegible] alive on 7 Feb 1946

Immediate cause of death: Heart Block — Duration: 1 mo approx.

Due to:

Due to:

Other Conditions: Hypertension — Duration: unknown

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Hulla M.D.

Address 211 N. Bradford St. Date signed 2 Feb 46

J Hulla

Correct age is especially important. Physicians: please write the

VS 150

G37242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G37242 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Dillon Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Dillon Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.
nc	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Dorothy Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1904

8. AGE: Years	Months	Days	If less than one day
41	6	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sherwood Bros.,
11. Industry or business

FATHER
12. Name Harry Webster Lewis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma E. Allen
15. Birthplace Baltimore, Md.

16 (a) Informant Dorothy Lewis - wife
(b) Address 3008 Dillon Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cemetery., Horner's Lane
Location

18 (a) Funeral director Charles E. Schimunek
(b) Address 2603 E. Madison Street.

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 February 1946, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Dec 1945 to 8 Feb 1946, and that I last saw h[illegible] alive on 8 Feb 1946.

	Duration
Immediate cause of death: Pulmonary Hemorrhage	4 days
Due to: Pulmonary Tuberculosis	2 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence W. LeDoux
Address 601 S. Ellwood ave. Date signed 2/9/46 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G37243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3137 Chesterfield Ave
(c) Hospital or institution: Balto. City

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Manokin
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Nettie A. Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 20, 1874

8. AGE: Years 71 | Months 9 | Days 18 | If less than one day .....hr. .....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business "

FATHER
12. Name George W. Ford
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte P. Wagnuck
15. Birthplace Maryland

16 (a) Informant Elmer Ford
(b) Address Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10/46 (month) (day) (year)

(c) Cemetery or crematory Salem
Location Manokin - Md

18 (a) Funeral director B. L. Hopkins
(b) Address Annapolis Md.

19 (a)..... (b).....
(Date rec'd by registrar) Registrar

FEB 8 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1946, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchogenic Carcinoma

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Daniel Skutarelis M.D.
Medical Examiner.
Date signed 2/8/46

G37244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G37244 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5028 E. Oliver (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jamea[illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-22

8. AGE: Years 25 | Months 0 | Days 12 | If less than one day hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Baldwin Ballard

13. Birthplace W Va

MOTHER 14. Maiden Name Martha Kendall

15. Birthplace W Va

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 1946 (month) (day) (year)

(c) Cemetery or crematory Ellison Lemon Location Monroe Co. W. Va.

18 (a) Funeral director Geo. L. Boyer Jr

(b) Address 1512 Hollins St

19 (a) FEB 9 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Feb 1946, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Feb 1946, to 8 Feb 1946 and that I last saw her alive on 8 Feb 1946

Immediate cause of death: lymphosarcoma generalized — Duration: 7 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Dx confirmed by biopsy

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William T. Dixon
Address Johns Hopkins Hospital Date signed 2/15/46

VS 150

G37245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G37245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave - Jan 29
(c) Hospital or institution:
Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William E. Mc Intyre

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Mary Mc Intyre

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5th 1857

8. AGE: Years 88 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Book Keeper

FATHER
12. Name Owen Mc Intyre
13. Birthplace Ireland

MOTHER
14. Maiden Name Kelly
15. Birthplace Ireland

16 (a) Informant Maria Del Manto
(b) Address 2035 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 FEB 9 1946 (Date rec'd by registrar) (b) Pennington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 19 46, at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to Feb 8 1946, and that I last saw him alive on 2/8 1946

Immediate cause of death
Cardiac failure
Due to Hypertension (Sec)
Due to Arterio Sclerosis

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Cottrell Jr.
Address St Agnes Hosp Date signed 2/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37246
Registered No.

487856 / 133a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Halcyon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Stallhorn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-72

8. AGE: Years 73 | Months 6 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Storeman
11. Industry or business

FATHER
12. Name August Stallhorn
13. Birthplace Germany.

MOTHER
14. Maiden Name Sofia Z.
15. Birthplace Germany.

16 (a) Informant Reynolds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Oliver & Greenmount

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7. 1946 at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1946 to Feb. 7 1946 and that I last saw him alive on Feb 7 1946.

Immediate cause of death: Renal insufficiency — Duration 1wk
Due to Bilateral Chronic Pyelonephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan L Lewis
Address Date signed 2/7/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

37247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37247 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3912 Foster Ave
(c) Hospital or institution:
26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40-yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 Foster Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F Reedt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Clara E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26 1879

8. AGE: Years	Months	Days	If less than one day
66	11	19	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name Dont Know

13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know

15. Birthplace Germany

16 (a) Informant Mrs Clara Reedt

(b) Address 3912 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9 46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home

(b) Address 2008 Orleans St

FEB 9 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1946, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1946, to Feb 7 1946, and that I last saw h[illegible] alive on Feb 6 1946

Immediate cause of death	Duration
Cerebral Hemorrhage Feb 7	1946
Myocarditis	1946
Due to Arteriosclerosis	1940
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J Lee M.D.

Address 350 E Lee Date signed 2/7/46

VS 150

G37248

BALTIMORE CITY HEALTH DEPARTMENT X G37248

CERTIFICATE OF DEATH 55E

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne
(c) City or town Grasonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lands End Farm (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Kienle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-17-84

8. AGE: Years 61 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Del (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name John A. Kienle
13. Birthplace Del

MOTHER 14. Maiden Name Margaret Aspen
15. Birthplace Del

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 11-46 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Wilmington Delaware

18 (a) Funeral director Dalton Bros
(b) Address Centreville Maryland

19 FEB 9 1946 (b) William M.D.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1946 at 1 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Feb 8 1946 and that I last saw h[illegible] alive on Feb 8 1946

Immediate cause of death: Cachexia, Pyrexia, Jaundice — Duration: 6wks

Due to: Lymphosarcoma

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Richards M.D. M.D.
Address Johns Hopkins Hosp Date signed 2/5/46

Funeral for William M.D.

VS 150

Ford X

Garies

G37249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G37249 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1549 Argyle Ave
(c) Hospital or institution:
(d) ~~Length~~ Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1549 Argyle Ave
(Or rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Garies

3 (b) If veteran, name war 1st
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1892

8. AGE: Years	Months	Days	If less than one day
53 54	3	27	hr. min.

9. Birthplace (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Garies
13. Birthplace N. C.

MOTHER
14. Maiden Name Rosa Harris
15. Birthplace N. C.

16 (a) Informant Nathaniel Garies
(b) Address 1549 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat. L. Cem.
Location Baltimore Md.

18 (a) Funeral director Wm. Chas. H. Hyland
(b) Address 1631 Druid Hill Ave

19 (a) FEB 9 1946 (Date rec'd by Registrar) (b) Registered by Huntington Wilkerson, M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/46 19 2/6/46 and that I last saw h[illegible] alive on 2/5/46 19

Immediate cause of death Embolism
Heart Failure

Due to Coronary Thrombosis
Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Chas. Hyland

Address 5 E. Mosher Date signed 2/7/46

X

G37250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

G37250

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Aliceanna Sts
(c) Hospital or institution: St Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5229 Cuthbert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Clark Dell

3 (b) Color or race, if not white, write the word: White
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Georgia Mary Dell
6 (c) If alive, give age: 46 years
7. Birth date of deceased (mo., day, yr.) 10/16/1895
8. AGE: Years 50 | Months 3 | Days 23 | If less than one day ... min.
9. Birthplace Carroll County Md.
(Town, county, and state)
10. Usual Occupation Street Car Conductor
11. Industry or business Balto. Transit Co.

FATHER
12. Name Grant Dell
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name
15. Birthplace Carroll Co. Md.

16 (a) Informant Georgia Mary Dell
(b) Address 5229 Cuthbert Ave
17 (a) Burial (Burial, cremation or removal) (b) Date thereof Feb 11 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Woodlawn Balto Co. Md.
18 (a) Funeral director Keller Funeral
(b) Address 4810 Liberty Heights Ave
19 (a) (b)
Received by registrar FEB 9 1946 Huntington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1946 at 8:15 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1946 to 2/8 1946 and that I last saw him alive on 1/28 1946
Immediate cause of death: Cardio Respiratory failure — Duration
Due to: Bilateral lacular pneumonia
Due to: Malignant hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Atherosclerosis, pneumonia

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frank J. Lyle Jr.
Address St Joseph Hosp Date signed 2/8/46

VS 150

G37251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1243

G37251

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: Univ. Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Angela Fanley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Victor Fanley
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Jan. 10 1908

8. AGE: Years	Months	Days	If less than one day
37	10	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home.

FATHER
12. Name George Bringman
13. Birthplace Wash. DC

MOTHER
14. Maiden Name Mary A Donoghue
15. Birthplace Baltimore

16 (a) Informant Victor Fanley
(b) Address 1818 N. Charles Street

17 (a) Burial (b) Date rec'd Feb 11 1946
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Phillips Lamborn
(b) Address 4510 Liberty Heights Ave

19 (a) (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS Form FEB 9 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1946, at 9.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1946, to 2-7 1946, and that I last saw h[illegible] alive on 2-7 1946.

Immediate cause of death Cerebro-vascular accident +

Due to

Due to

Other Conditions Chr. endocarditis - hyaline nephritis - anemia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George B. Callender M. D.
Address Univ. Hosp. - Redwood & Green Date signed 2-7-46

83a

Trocki

G37252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. G37252

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 S. Duncan St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antoinette (Nenie - Jennie) Trocki

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Of late Peter Trocki

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 1898

8. AGE: Years 47 | Months 10 9 | Days — | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mr. Paul Trocki

(b) Address 416 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Herman Mill Road

18 (a) Funeral director Stephen J. Duckworth, Inc.

(b) Address 1000 S. Kenwood Ave.

19 (a) FEB 9 1946 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1946 at 11 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 6 1946 and that I last saw h alive on Feb 6 1946

Immediate cause of death	Duration
Metastasis from	
Due to adeno Carcinoma Rectum	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Feb 15-1945

Major findings of operation: carcinoma of rectum

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert Mortimer

Address 2706 St Paul St Date signed 2/8/46

X

G37253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G37253

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15-17 - Linden Ave -
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randall Vaughan Raser ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/46

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earle Raser.
13. Birthplace Pa

MOTHER
14. Maiden Name Genevie Dean
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) FEB 3 1946 (b) Huntington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1946 at 4 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1946 to 2-7 1946 and that I last saw him alive on 2-7 1946

Immediate cause of death	Duration
Acidosis, severe	
Due to Acute nutritional disturbance with diarrhea and vomiting	
Due to Septicemia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George L. Palmer M.D.
Address Johns Hopkins Hosp. Date signed 2-7-46

X

637254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5413

Registered No. 637254

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Minn. (b) County
(c) City or town South Minneapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 13th Av. S.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman McQuist Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-41

8. AGE: Years	Months	Days	If less than one day
4	10	25	hr. min.

9. Birthplace Minn.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Norman Quist.
13. Birthplace Minn.

MOTHER
14. Maiden Name Pauline A. Flowne
15. Birthplace Minn.

16 (a) Informant Norman McQuist
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 9/46 (month) (day) (year)
(c) Cemetery or crematory Minn.
Location Minneapolis Minn.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1908 Eutaw Place

FEB 9 1946 (Date rec'd by Registrar) (b) Huntington Will Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1946, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1946, to 2-8 1946 and that I last saw him alive on 2-8 1946.

Immediate cause of death	Duration
Brain Tumor, cerebellar (malignant)	3 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/5/46
Major findings of operation malignant cerebellar tumor
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Antonio Quidelanilla M.D.
Address The Johns Hopkins Hosp. Date signed 2/8/46

G37255

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a Reg. Dist. No.

G37255

1. PLACE OF DEATH:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Length in above place of death?

Hospital, institution, or street address where death occurred: 4013 Liberty Heights Ave 15

Length in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4013 Liberty Heights Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

(a) FULL NAME: Fannie Margaret Givens

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	3. (b) Social Security Number
F	W	widowed	

(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Date of birth of deceased (mo., day, yr.): Jan 4, 1861

8. AGE: Years: 84 | Months: 1 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: None

11. Industry or business:

12. Name of father: William C. Turner

13. Birthplace of father: Maryland

14. Maiden name of mother: Margaret Pattey

15. Birthplace of mother: Maryland

16. Informant: Mrs. Capes

17. Address: 4 Lit Hughes Ave. Balto 7

18. Burial, cremation, or removal. Which?: Burial Date thereof: 2/11/46 (month) (day) (year)

19. Cemetery or crematory: Evergreen

20. Location: Berwyn Md

21. Funeral director: John E. Mitchell & Son

22. Address: 1900 Eutaw Place

Filed: FEB 9 1946 Registrar: Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 9, 1946; at 3 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to Feb 9 1946 and that I last saw him alive on Feb 9, 1946

Immediate cause of death: Cer. Art. Insufficiency

Due to:

Due to:

Other conditions: Arteriosclerosis, Hypertension, Cerebral Lesion

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION
5
?

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Md Date signed: 2/9/46

G37256 BALTIMORE CITY HEALTH DEPARTMENT G37256

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-3488

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	22	hr. min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name John T. Meyer

13. Birthplace Balto. Co. Maryland

MOTHER 14. Maiden Name Kate Robinson

15. Birthplace Balto. Co. Maryland

16 (a) Informant Mrs. Katherine Hunt

(b) Address 100 Goldspring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/1946 (month) (day) (year)

(c) Cemetery or crematory Carroll M.E. Church.

Location Chestnut Ridge, Balto. Co.

18 (a) Funeral director Howard A. Dill

(b) Address 19[illegible] Penna. Ave. Towson

19 (a) FEB 9 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH February 8, 1946 at 1 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Skuberlic M.D. Medical Examiner.

Date signed 2/8/46.

VS 151

637257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1946

637257 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2641 Purnell Drive.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK R. WATSON

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 217-07-7669

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Watson
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1882

8. AGE: Years 63 | Months 4 | Days 3 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Accountant.
11. Industry or business Baroleum Dist. Co.

FATHER
12. Name Charles Watson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Waters.
15. Birthplace Baltimore Md.

16 (a) Informant Charles R. Watson.
(b) Address 2641 Purnell Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore County Md.

18 (a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) FEB 9 1946 (Date rec'd by Registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1946, at 3½ A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw DEAD ON ARRIVAL TO HOSP.

	Duration
Immediate cause of death massive pulmonary edem	
Arteriosc. Heart Dis And	2 years (+)
Hypertensive Cardiac Disease	
Due to The	
3 cerebral hemorrhage left	1 hour
Due to middle cerebral artery	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Purnell Katz M. D.
Address Sinai Hosp Date signed 2-8-46

G37258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G37258

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Leadenhall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~ 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Leadenhall St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ~ years

3 (a) FULL NAME Harriett Minor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-13-1880

8. AGE: Years 65 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business ~

FATHER
12. Name Thomas Holloway
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Jurricks
15. Birthplace Md.

16 (a) Informant James W. Parker
(b) Address 1108 Leadenhall St

17 (a) Burial (b) Date thereof 2/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Sarah J Brumpton
(b) Address 1810 Montgomery St

19 (a) Date rec'd by Local Reg. FEB 9 1946 (b) Huntington Hollingsworth Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1946 at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6- 1946 to 2-7- 1946 and that I last saw her alive on 2-7- 1946

	Duration
Immediate cause of death Acute Coronary Occlusion	2 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury ~

23. Signature C. M. Lawrence M. D.
Address 1022 W. Lanvale St. Date signed 2/8/46

X

G37259

CMK-97181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G37259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 29
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~XXXX~~ 943 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Joseph Hajek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar. 23-1882

8. AGE: Years 63 | Months 10 | Days 14 | If less than one day: hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Vincentalaw Hejek
13. Birthplace Czechslovakia

MOTHER
14. Maiden Name Anna Cevenka
15. Birthplace Czechslovakia

16 (a) Informan Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director Frank Brachbon
(b) Address 900 W. Chester St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 9 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1946, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1945 to Feb. 7 1946, and that I last saw him alive on Feb. 7 1946

Immediate cause of death: Pulmonary Tuberculosis ? — Duration ?

Due to

Due to

Other Conditions Tuberculous Laryngitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 2/7/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Elzie Jones ✓

G37260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G37260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1371 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1371 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elzie Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 38 37 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace Md

MOTHER
14. Maiden Name Bertha Norman
15. Birthplace Md

16 (a) Informant Bertha Jones
(b) Address 1371 N. Calhoun St

17 (a) Burial (b) Date thereof 2 12 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto National
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1302 Pennsylvania Ave

19 (a) (b)
Registrar

FEB 9 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 46, 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1945 to 2/5 46, and that I last saw h— alive on 2/7 1946.

Immediate cause of death Pleurisy

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. M. Rhetta M. D.

Address 213 N. Dith Date signed 2-7-46

B. M. Rhetta

Please write the causes of death clearly and legibly. Physicians: please write in full, without abbreviations, the correct age in years, months, days, hours, or minutes. Every item of information should be carefully supplied. The correct age is especially important.

G37261

CWK-75160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G37261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 9- 27
(e) Length of stay in Baltimore (yrs., mos., or days) 79- 9- 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 East Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: James Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Ella Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21-1866

8. AGE: Years	Months	Days	If less than one day
79	9	15	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Cook
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Dorsey
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 9 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A Co

18 (a) Funeral director Rayner Saunders
(b) Address 1442 E Preston St

19 (a) FEB 9 1946 (Date rec'd by registrar) (b) Thomas F. Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1942 to Feb. 6 1946 and that I last saw him alive on Feb. 6 1946

Immediate cause of death	Duration
Bronchopneumonia	3
Due to	
Due to ASHD	?
Fracture left femur.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec. 29, 1945 M
(c) Where did injury occur? Baltimore, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury Fall to floor

23. Signature Margaret Sullivan
Address B. C. H. Date signed 2/7/46

Subject to approval of Medical Examiner
Thomas J. Wilson, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G37262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2433 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2433 Fleet st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Cichocki

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Cichocki
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Nov. 1895

8. AGE: Years	Months	Days	If less than one day
50	3		hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Casimer Kwiatkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Emale
15. Birthplace Poland

16 (a) Informant Joseph Cichocki
(b) Address 2433 Fleet st.

17 (a) Burial (b) Date thereof 2-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director Geo. A. Weber
(b) Address 704 S. Ann st

19 (a) FEB 9 1946 (b) Lexington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1946 at 7½ A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to self hanging, result of mental condition.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/8/46 at 7 A. M.
(b) Where did injury occur? 2433 Fleet st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Hanging by sash cord

23. Signature Benedict Skiuretic M.D.
Medical Examiner.
Date signed 2-8-46

VS 151

G37263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G37263

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution St Joseph's Hospital 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St Anthonys Convent
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Lavina, O.S.F. - ANNA SCHLUND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/77

8. AGE: Years 68 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace York Penna
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Sebastian Schlund
13. Birthplace Penna

MOTHER
14. Maiden Name Anna Kunkel
15. Birthplace Penna.

16 (a) Informant Sister Superior O.S.F.
(b) Address St Joseph's Hospital

17 (a) Burial (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

FEB 9 1946
(Date rec'd by registrar)

(b) Harrington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1946 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1945 to 2/8 1946, and that I last saw her alive on 2/8 1946

Immediate cause of death: Cardio Respiratory failure — Duration

Due to: Hypertension cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Lloyd Jr. M.D.

Address St Joseph's Hosp Date signed 2/9/46

VS 150

G37264 Dr Johnson Yield fd ✓ BALTIMORE CITY HEALTH DEPARTMENT Registered No. G37264

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2219 Hargrove Ally
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give county)
(d) Street No. 2219 Hargrove Ally (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie Awkward
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7 1905

8. AGE: Years 40 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Bath Co Ky (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name James E Awkward
13. Birthplace Bath Co. Ky

MOTHER 14. Maiden Name Elizabeth Thoms
15. Birthplace Bath Co Ky

16 (a) Informant Mary E Green
(b) Address 2219 Hargrove Ally

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robt E Williams
(b) Address 1545 McElderry St

19 (a) FEB 9 1946 (Date rec'd by registrar) (b) Washington Pollia Wray M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1946, at 6 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 1 1945 to Feb 7 1946, and that I last saw h[illegible] alive on Feb 6 1946.

Immediate cause of death	Duration
Cardio-Renal disease	3 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas A. J. Lyman M. D.
Address 2219 Guilford Ave Date signed Feb 9-46.

VS 150.

Please write in ink; PRINT CAPITAL LETTERS. Information should be complete and correct as to spelling. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. The correct age is especially important.

G37265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G37265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 Beale Ct.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Beale, Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Etta Newman Brooks

3 (b) If veteran; name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days.	If less than one day
52			hr. min.

9. Birthplace Bath Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Marsh ?
15. Birthplace Md

16 (a) Informant Allen Brooks
(b) Address 214 Beale Ct.

17 (a) Burial (b) Date thereof Feb 11-1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert F. Williams
(b) Address 15-15 McElderry St

19 (a) FEB 9 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Sept 1943 to 7 Feb 1946 and that I last saw h er alive on 6 Feb 1946

Immediate cause of death: acute myocardial dilitation — Duration 15 Mins.
Due to: Apoplexy. — Duration 15 Mins.
Due to: —
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Burwell

Address 121 Virginia Date signed 2-7-46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G37266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Balt. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 Baker St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles S. Long

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-03-7608

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Hale Long
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1/1893

8. AGE: Years	Months	Days	If less than one day
52	10	7	.....hr. .....min.

9. Birthplace Westover Md
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business F A Davis & Son

FATHER
12. Name Edwin D Long
13. Birthplace Westover Md

MOTHER
14. Maiden Name Fannie Broughton
15. Birthplace Maryland

16 (a) Informant Mary Hale Long
(b) Address 2928 Baker St

17 (a) Burial (b) Date thereof Feby 14/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethel Church Cemetery
Location Lively Kilmarnock Va.

18 (a) Funeral director Harry N. Annucci
(b) Address 4204 Edgewood Ave

19 FEB 9 1946 (Date rec'd by registrar) Huntington Williamsburg Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1946, at 8:00 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature C. P. Lubaski M.D.
Medical Examiner.
Date signed 2/13/46

VS 151

G37267 ✓ G37267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Argyle ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 19yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Argyle ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Jannie Chavis

3 (b) If veteran, name war ____

3 (c) Social Security Account No. ____

4. Sex female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife William Chavis

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) November 9, 1868

8. AGE: Years 77 | Months 2 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Lillington, N.C.
(Town, county, and state)

10. Usual Occupation ____

11. Industry or business ____

FATHER
12. Name Robert Kearney
13. Birthplace Lillington, N.C.

MOTHER
14. Maiden Name Londine ?
15. Birthplace ? N.C.

16 (a) Informant Blanche Lewis
(b) Address 1001 Argyle Ave

17 (a) Burial (b) Date thereof 2-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location ____

18 (a) Funeral director Mr. Kate R. Williams
(b) Address 3215 N. Schroeder St.

19 (a) FEB 9 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 February 1946 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1.8.46 19__ to 2.5.46 19__, and that I last saw her alive on 2.4.46 19__.

Immediate cause of death: Pulmonary Congestion — Duration 2.4.46

Due to: Senility

Due to: ____

Other Conditions: ____
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ____

Of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature James M. Pair M. D.
Address 460 N. Carrollton Date signed 2.9.46

Correct age is supremely important. Physician: please write the

G37268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1410

G37268 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the information correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 N. Strieker (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Esther Woods

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Clio Woods

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-11-19

8. AGE: Years 26 | Months 5 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Oscar Harris
13. Birthplace N.C.

MOTHER
14. Maiden Name Lona Clay
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-9-'46. (month) (day) (year)
(c) Cemetery or crematory.....
Location Raleigh, N. C.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroder St.

FEB 9 1946 (Date rec'd by registrar) (b) Huntington-Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1946 at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1946, to Feb 8 1946 and that I last saw h.. alive on Feb 4 1946.

Immediate cause of death? Pulmonary infarction	Duration
Due to pelvic phlebitis?	
Due to miscarriage	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation: Bacterial Endocarditis
of autopsy Tricuspid Valve. Pulm infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Thomas H Stephens M. D.
Address Johns Hopkins Hosp. Date signed 2-8-46

VS 150

G37269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G37269

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSEVELT PAYNE

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-0436

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1917

8. AGE: Years	Months	Days	If less than one day
29	4	23	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Forman Payne
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace N. C.

16. (a) Informant M's Emma Davis
(b) Address 604 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 9 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1946 to 2-6-1946 and that I last saw h[illegible] alive on 2-6-1946.

Immediate cause of death: Lobar Pneumonia — Duration 5 da.

Due to Virus & Bronchitis — Duration 2 wk

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Geo. R. Blake M.D.
Address 1327 N. Central Ave. Date signed 2/8/46

G37270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G37270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW PARKER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-1-1901

8. AGE: Years 44 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Sam Parker
13. Birthplace N.C.

MOTHER
14. Maiden Name Sallie Smith
15. Birthplace N.C.

16 (a) Informant Cousin
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-46 (month) (day) (year)
(c) Cemetery or crematory
Location Stonewall, N.C.

18 (a) Funeral director Mrs. Frances Kemble
(b) Address 576 W. Biddle St

19 (a) FEB 9 1946 (Date rec'd by registrar) (b) Registrar

Number for Hillsborough

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1946, to 2-8 1946, and that I last saw h.i.m. alive on 2-8 1946.

	Duration
Immediate cause of death Pulmonary Embolism, Multiple, Massive Bilateral	Unknown
Due to Thrombosis, Deep Veins of Legs	?
Due to	
Other Conditions Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr. Abner

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Williams, M.D.
Address Johns Hopkins Hospital Date signed 2-9-46

VS 150

100 B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G37271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 W Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1893

8. AGE: Years 52 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Matron

11. Industry or business

FATHER
12. Name Harry Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Olivia Harvey
15. Birthplace Balto. Md.

16 (a) Informant John H. Thomas
(b) Address 503 W. Lanvale St

17 (a) Burial (b) Date thereof Feb. 10, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 2-9 1946 (b) Huntington-Williams Co.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1946, at 9:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2-6-46

G37272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registration No. G37272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 Bloom St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Bloom St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race col | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-22

8. AGE: Years 23 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Mobile Ala.
(Town, county, and state)

10. Usual Occupation Helper

11. Industry or business

FATHER 12. Name Edward Webb

13. Birthplace Ala

MOTHER 14. Maiden Name Cynthia Roberts

15. Birthplace Ala

16 (a) Informant Cynthia Webb

(b) Address 556 Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Md

18 (a) Funeral director Beg. E. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) FEB 10 1946 (Date received by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7-1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1946 to 2-7 1946 and that I last saw him alive on 2-6-1946

Immediate cause of death Pulmonary Tuberculosis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Huntington W. Va. Signed 2/11/46

VS 150

correct age is especially important. Physicians: please write the

G37273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G37273 Registered No. 698

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 N. Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Morris Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	widowed

6 (b) Name of husband or wife Henrietta Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1863

8. AGE: Years	Months	Days	If less than one day
82	6	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name John Morris
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Mrs Beth Harrid
(b) Address 1023 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Riesterstown Rd

19 (a) FEB 10 1946 (Date received by Registrar) (b) Huntington White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-1946, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-1946 to 2-8-1946 and that I last saw him alive on 2-7-1946.

Immediate cause of death Cerebral Hemorrhage — Duration 12-15-45

Due to Hypertension and arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel A. Saunders

Address 1029 N Stricker St Date signed 2-8-46

VS 150

G37274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G37274 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3333 N. Charles Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** KATHERINE ROTH BUCHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Frederick Bucher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1853

8. AGE: Years	Months	Days	If less than one day
89	3	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Roth
13. Birthplace Germany

MOTHER
14. Maiden Name Christina ?
15. Birthplace Germany

16 (a) Informant Mr. Irvin F. Bucher
(b) Address Charles Apts

17 (a) Burial (b) Date thereof 2-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date received (month) (day) (year) (b) Signature of Registrar

FEB 9 1946

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH Feb. 8 1946, at 845 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1946, to Feb 8 1946, and that I last saw h alive on Feb 8 1946

Immediate cause of death	Duration
Cardiac failure	1 day
Due to Bronchopneumonia	2 days
Arterio-Sclerosis	89 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. Frederick Lantz M. D.
Address Temple Garden Apts Date signed 2/10/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 637275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7253 Holabird Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Dock Reeves Dickinson

3 (b) If veteran, name war: no

3 (c) Social Security Account No. [redacted]-14-6419

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah Elizabeth

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Mar. 23, 1867

8. AGE: Years 78 | Months 10 | Days 16 | If less than one day: hr. min.

9. Birthplace: Pittsylvania, Va
(Town, county, and state)

10. Usual Occupation: R.R. Operator

11. Industry or business

FATHER
12. Name: John Dickinson
13. Birthplace: Pittsylvania, Va

MOTHER
14. Maiden Name: Harriett Reeves
15. Birthplace: Pittsylvania, Va.

16 (a) Informant: Mrs. S.H. Myers
(b) Address: 7253 Holabird, Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory: Leemond Cemetery
Location: Danville, Va.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 10 1946 (Date received by registrar) Thomas J. Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1946, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Traumatic shock
Compound fracture rt. leg
Fracture of pelvis; abdominal
Due to hemorrhage; Contusion of
brain;
Other Conditions: Pulmonary Congestion.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-7-46 at 8:35 P.M.
(b) Where did injury occur: Holabird & Moravia Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Struck by auto

23. Signature: Benedict Skotarelis M.D.
Medical Examiner.
Date signed 2/9/46

VS 151

G37276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37276 / 64 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3741 St. Margaret St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Carter Burton

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1945

8. AGE: Years	Months	Days	If less than one day
	7	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Mr. Rudolph W. Burton
13. Birthplace Hillsboro, Texas

MOTHER
14. Maiden Name Dorothy M. Bowersox
15. Birthplace Punxsutawney, Pa.

16 (a) Informant Mr. Rudolph W. Burton
(b) Address 3741 St. Margaret St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/10/46 (month) (day) (year)
(c) Cemetery or crematory Circle Hill
Location Punxsutawney, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 (a) (Date rec'd by registrar) (b) 0 Registrar

FEB 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1946, at 11 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymicus - Lymphaticus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Feather M.D.
Medical Examiner.
Date signed Feb. 9 1946

X

G37277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37277 Registered No. 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Evelyn P. Baylis Johnson

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leonard Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1899

8. AGE: Years 46 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Wm Pacy
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Collin Debby
15. Birthplace Carroll Co

16 (a) Informant Eva. Madden
(b) Address Carroll Co. Reisterstown

17 (a) Burial (b) Date thereof Feb. 12 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Lukes
Location Balto Co.

18 (a) Funeral director J. F. Cline & Sons
(b) Address Reisterstown Md.

19 (a) (b) Thomas J. McMullen
(Date rec'd by Registrar) Registrar

FEB 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1946, at 1.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1946, to Feb 9 1946, and that I last saw her alive on Feb 7 1946.

Immediate cause of death: Acute Myelogenous Leukemia — Duration: 6 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Armand Weisner M. D.

Address Univ. Hosp. Date signed 2/9/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37278

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G37278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md.~~ Pa. (b) County
(c) City or town Peach Bottom
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Graybeal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Mock.
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) May 1. 1893

8. AGE: Years	Months	Days	If less than one day
52 53	9	8	hr. min.

9. Birthplace Ash Co. N. C.
(Town, county, and state)
10. Usual Occupation Farmer.
11. Industry or business

FATHER 12. Name Wm Graybeal
13. Birthplace N C,

MOTHER 14. Maiden Name Ruth Mock
15. Birthplace N C

16 (a) Informant Harold Graybeal.
(b) Address Peach Bottom Pa.

17 (a) Burial (b) Date thereof Feb. 13. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Little Brittain
Location Lancaster Co. Nottingham Pa.

18 (a) Funeral director F. L. Charlton
(b) Address Peach Bottom Pa.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1946, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1946 to 2/9 1946, and that I last saw him alive on 2/9 1946

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Ht. Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Good M. D.
Address Md. Gen. Hospital Date signed 2/11/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

937

G37279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37279 Registered No. 137a

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland General Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Roslyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Francis Brookey

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Mary Ellen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/21/59

8. AGE: Years 86 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Frederick Md. (Town, county, and state)

10. Usual Occupation Retired Inspector

11. Industry or business Ft Pitt Brush Co.

FATHER 12. Name Peter Brookey

13. Birthplace Germany

MOTHER 14. Maiden Name Ellen Todd

15. Birthplace Md.

16 (a) Informant William J. Brookey

(b) Address 2218 Roslyn Ave.

17 (a) Burial (b) Date thereof 2-11-46 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Johns

Location Frederick, Md.

18 (a) Funeral director H. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) (b) (Date rec'd by registrar) Registrar

FEB [illegible] Huntington [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1946 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1946 to 2/8 1946 and that I last saw him alive on 2/8 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1/13/46

Major findings of operation: Enlarged Prostate

of [redacted] Transurethral Resection

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide [redacted]
(b) Date of occurrence 2/8 at 5 P M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C H Frye Jr M. D.

Address [illegible] Date signed 2/8/46

X

G37280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37280 / 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Jacksonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. Luther J. Kiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1891

8. AGE: Years	Months	Days	If less than one day
54	8	13	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business

FATHER
12. Name Samuel J. Kiger
13. Birthplace Penna.

MOTHER
14. Maiden Name Anna Belle Stiles
15. Birthplace Penna.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington Del.

18 (a) Funeral director John C Moran
(b) Address 2000 E Baltimore St

FEB 10 1946

19 (a) (Date rec'd by registrar) (b) Wilmington, Del. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1946, at 2 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 8 1946, and that I last saw him alive on Feb 8 1946.

Immediate cause of death	Duration
Terminal pneumonia	
Due to carcinoma & metastases from the left salivary gland	
Due to (Primary Malig)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Schwinger M.D.
Address Medical Arts Bldg Date signed 2/9/46

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G37281 Registered No.

Please write the causes of death clearly and legibly. Physicians: please report age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town East Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 55 Trenton Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William John Cole

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hannah Kritch Cole
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1886

8. AGE: Years	Months	Days	If less than one day
59 60	2	20	hr. min.

9. Birthplace Conception Harbor, Newfoundland.
(Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business Merchant Seaman

FATHER
12. Name William J. Cole.
13. Birthplace Same

MOTHER
14. Maiden Name Fanny Williams
15. Birthplace Same

16 (a) Informant Patient. Records.
(b) Address U.S. Marine Hospital
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)
(c) Cemetery or crematory
Location Boston Mass
18 (a) Funeral director John C. Moran
(b) Address 3000 E Baltimore St
19 (a) (Date received by registrar) (b) Signature of registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9th 1946, at 3:20 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/10/46 19 to 2/9/46 19, and that I last saw him alive on 2/9/46 19

Immediate cause of death	Duration
Carcinoma of the stomach with generalized abdominal	
Due to metastases.	1 Yr.
Paritonitis, generalized,	
Due to post operative.	15 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1/28/46
Major findings of operation: Carcinoma of stomach with metastases.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Emerson J. Gledhill M. D.
Address U.S. Marine Hospital Date signed 2/9/46

VS 150

G37282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37282 Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18da.
(e) Length of stay in Baltimore (yrs., mos., or days) 18da

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Talbot
(c) City or town EASTON (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. #1 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) **FULL NAME** BONNIE MIELKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wh.	Married

6 (b) Name of husband or wife GUSTIE FRED MIELKE
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 13, 1888

8. AGE: Years	Months	Days	If less than one day
57	67	10 28	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name SPURGEON BECKNER
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name MARY JANE GRAY
15. Birthplace VIRGINIA

16 (a) Informant Hospital Records
(b) Address Union Memorial Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 13 - 46 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cemetery
Location Easton, Md.

18 (a) Funeral director Stewart and Mowen Co.
(b) Address 108 West North Ave. Balto. Md.

19 (a) (Date received by registrar) (b) Registrar

B 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1946, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23-46 19..., to 2-10 19 46 and that I last saw her alive on 2-9- 1946

Immediate cause of death UREMIA

Due to CHR. NEPHRITIS & NEPHRO LITHIASIS IN ONLY KIDNEY

Due to

Other Conditions Hypertens. CVD

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gayle B. Stewart M. D.
Address U.M.H. Date signed 2-10-46

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G37283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Beecher (Clover) CLOWER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Roseanna G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1905

8. AGE: Years	Months	Days	If less than one day
40	9	2	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Motorman
11. Industry or business B. T. Co.

FATHER
12. Name E. R. Clower
13. Birthplace Va

MOTHER
14. Maiden Name ? Loukus
15. Birthplace Va

16 (a) Informant Talmadge E Clower
(b) Address 1605 Light St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 10, 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Princeton W. Va

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 (a) FEB 11 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9th 1946, at 10 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Embolism, Infarctions of Myocardium

Due to Vegetative Aortic Valvulitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 2-9-46

VS 151

G37284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G37284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ESSEX
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 S. Taylor Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hartzell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31 - 1880

8. AGE: Years 65 | Months — | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Oakland Garrett Co Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Chas. Ross
(b) Address 337 Taylor Ave. Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-46 (month) (day) (year)

(c) Cemetery or crematory ?
Location OAKLAND MD.

18 (a) Funeral director John G. Connolly
(b) Address 416 Eastern Ave. Essex

19 (a) FEB 11 1946 (Date rec'd by registrar) (b) [illegible] for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1946 at 7:40 AM

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intracranial hemorrhage
Fracture of left arm
Fracture of 4-5-7 ribs, left.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-9-46 at Balto Co. 3:15 A. M.
(b) Where did injury occur Eastern & Taylor Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto struck by auto.

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2/9/46.

G37285 G37285

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 167E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5521 Patrick Henry Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joyce May Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 26 - 1945

8. AGE: Years | Months: 2 | Days: 12 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Lloyd R. Campbell
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Hensley
15. Birthplace Baltimore, Md.

16 (a) Informant Lloyd R. Campbell
(b) Address 5521 Patrick Henry Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave.

18 (a) Funeral director John J. Connelly.
(b) Address 419 Eastern Ave. Essex 21

19 (a) FEB 11 1946 (Date rec'd by Registrar) Huntington for Milton A. Helm, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1946, at 12 N ~~PM~~

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1946, to Feb 7 1946, and that I last saw him alive on Feb 7 1946

Immediate cause of death	Duration
Cardiac failure	5 days
Due to Congenital heart disease	2 1/2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary stenosis, aorta from R. ventricle

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Streeter M. D.
Address Union Memorial Date signed 2-7-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

37286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G37286 Registered No.

Type or print clearly in black ink. Physicians: please write the cause of death clearly and legibly. Current age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County
(c) City or town Mont Clair (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Trinity Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Tudor Farmer, Junior

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Esther Cane Farmer
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 9/10/05

8. AGE: Years	Months	Days	If less than one day
40	5	0	hr. min.

9. Birthplace Woodbridge, New Jersey (Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Maritime Service

FATHER
12. Name Henry Tudor Farmer
13. Birthplace Allendale, South Carolina

MOTHER
14. Maiden Name Annie Little
15. Birthplace Mississippi

16 (a) Informant Patient
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1946 (month) (day) (year)
(c) Cemetery or crematory Montclair N.J.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

FEB 11 1946 (Date rec'd by registrar) (b) Arlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/46 19..., at 1:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30/46 19..., to 2/10/46 19..., and that I last saw him alive on 2/9/46 19...

Immediate cause of death	Duration
Lymphoblastoma of stomach with metastasis to lungs, kidneys, skin	2½ months
Due to	
Due to	
Other Conditions Chronic Poliomyelitis (quiescent) (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Lymphoblastoma with above metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C.S. Mead Lt. M.C. U.S.N.
Address US Marine Hosp. Date signed 2/10/46 M.D.

VS 150

G37287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 Dumbarton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Dumbarton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie M. Pettit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed or~~ divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 19th 1866

8. AGE: Years	Months	Days	If less than one day
79	11	20	hr. min.

9. Birthplace Norfolk Va.
(town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William L. Pettit
13. Birthplace Fairfax Va.

MOTHER
14. Maiden Name Martha Cooke
15. Birthplace Isle of Wight Va.

16 (a) Informant Robert L. Reamy
(b) Address 1310 E. Belvedere Ave

17 (a) Burial (b) Date thereof 2/12/46
(Burial, cremation, or entombment) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9th 1946, at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1939, to Feb 9th 1946 and that I last saw ~~it~~ alive on Feb 8 1946

Immediate cause of death Arteriosclerotic heart disease — Duration 5 yrs

Due to arteriosclerosis, general. — 10 yrs

Due to senility — 10 yrs

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Chaffee M.D.
Address 6210 York Rd Date signed 2-10-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1812

Registered No. G37288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 N Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 N Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Geoghegan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1882

8. AGE: Years	Months	Days	If less than one day
63	5	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Fireman Trains

11. Industry or business

FATHER
12. Name James A Geoghegan
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Roten
15. Birthplace Md

16 (a) Informant Mary A Geoghegan
(b) Address 2317 N Monroe St

17 (a) Burial (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Wilson Lord Inc
(b) Address 1217 E Fayette St

19 (a) FEB 11 1946 (b) Interring or Williamsport Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1946, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1940 to 2/8 1946, and that I last saw h[illegible] alive on 2/5 1946.

Immediate cause of death: Cardio vascular — Duration 5 yrs

Due to renal disease

Due to Arterio Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D Volenick M.D.

Address 2710 Liberty St Date signed 2/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

37289

AB-98680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G37289 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Wilmot Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James H. Hunter

3 (b) If veteran, name war 40

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14- 1870

8. AGE: Years	Months	Days	If less than one day
75	7	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George W. Hunter
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Norris
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director William Lorh Inc
(b) Address 1217 E Cen St

19 (a) (Date rec'd by reg.) (b) Huntington for Williams Md Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Feb. 9 1946, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17- 1946 to 2-9- 1946, and that I last saw h im alive on 2-9- 1946

Immediate cause of death Bronchopneumonia — Duration ?

Due to Senility — ?

Due to

Other Conditions Arteriosclerosis of aorta Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: at grave

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. S. Gerrigan

Address Baltimore City Hall Date signed 2-10-46 (M. D.)

153

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G37290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G37290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 Huntridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Huntridge Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ellen Price

3 (b) If veteran, name war: n/e
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Widower
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 14 1863

8. AGE: Years	Months	Days	If less than one day
82	9	26	hr. min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Oliver C Berry
13. Birthplace Ga

MOTHER
14. Maiden Name Margaret Young
15. Birthplace Ga

16 (a) Informant Mr Coe State
(b) Address 1523 Huntridge Rd

17 (a) Funeral (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location Mt Lebanon Cem

18 (a) Funeral director Fulton Lo Dan
(b) Address 1317 E Pont St

19 (a) FEB 11 1946 (b) Lurtagh for Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946; at 1 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1945 to Feb 10 1946 and that I last saw h[illegible] alive on Feb 9 1946.

Immediate cause of death

	Duration
Cardio-Vascular-	
Due to hypertensive disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L Todd M. D.
Address Feb. 10-1946 Date signed
X 2108 St Paul St.

VS 150

Please write plainly; with ink or indelible pencil. Every item of information should be correctly supplied. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G37291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 D

G37291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights
(c) Hospital or institution: Wedd Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PARALIE WAITES

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No.

4. Sex	5: Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Samuel C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 18-1867

8. AGE: Years	Months	Days	If less than one day
78	9	30 ? 2	hr. min.

9. Birthplace Alabama. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John H. Morrell
13. Birthplace Alabama

MOTHER
14. Maiden Name Malinda C. Harris
15. Birthplace Alabama.

16 (a) Informant Dewey C. Waites
(b) Address 206 E. Preston, St.

17 (a) Transit- (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Bessemer
Location Alabama.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) FEB 11 1946 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946, at 1 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945 to 10 Feb 1946, and that I last saw her alive on 6 Feb 1946

Immediate cause of death Squamus cell Carcinoma right jaw — Duration 14 mos
Due to Cervical Metastases — 11 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Sept 14-1945
Major findings of operation: as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Swinnatin
Address Medical Arts Bldg Date signed 10-Feb 46

VS 150

X

637292

CWK-98897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 1

Registered No. 637292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1154 N. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE Years	Months	Days	If less than one day
67 ?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Lee
13. Birthplace ?

MOTHER
14. Maiden Name Eveline ?
15. Birthplace ?

16 (a) Informant Record-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1946 at 6:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1945 to Feb. 6 1946 and that I last saw h.er alive on Feb. 6 1946

Immediate cause of death Carcinomatosis — Duration 3

Due to Primary site Jaw — ?

Due to

Other conditions Generalized Edema — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Balt City Hosp. Date signed 2-9-46 M. D.

X

Please write plainly, with unfading ink. Employ a competent person to fill out this certificate. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37293 G37293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5105 Beaufort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5105 Beaufort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia P. Horn.

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James Horn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1878

8. AGE: Years 67 | Months 11 | Days 17 | If less than one day hr. min. 16

9. Birthplace Phila. Pa.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business Home.

FATHER 12. Name Edward Gray

13. Birthplace Boston, Mass.

MOTHER 14. Maiden Name Fanny England

15. Birthplace Phila. Pa.

16 (a) Informant Mr. James E. Horn

(b) Address 5105 Beaufort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location Woodlawn, Md.

18 (a) Funeral director Harry Sapp

(b) Address 525 Park Ave

19 (a) FEB 11 1945 (Date received by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945, to Feb 8 1945, and that I last saw h[illegible] alive on Feb 8 1945

	Duration
Immediate cause of death Myocarditis	6 Mo
Due to Pneumonia	1945
Due to General Weakness	
Other Conditions Premature Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Mills M.D.

Address 526 Park Ave Date signed Feb. 10 45

G37294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30

G37294

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 4500 Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Laura Dodd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/77

8. AGE: Years 68 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name William Ruckle
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Estelle Ball
15. Birthplace Baltimore Md

16 (a) Informant Charles Ruckle
(b) Address 1714 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E North Ave

18 (a) Funeral director Wendell E Humphreys
(b) Address 662 Harford Rd

19 (a) FEB 11 1946 (Date received by registrar) Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1946, at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 1946 to 2/8 1946, and that I last saw h. alive on 2/8 1946.

Immediate cause of death Cardio-respiratory failure

Due to Dissecting aneurysm of ascending aorta with rupture into pericardium

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: of above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J Lyde Jr
Address St Joseph's Hosp Date signed 2/8/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G37295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecilia Rodgers Du Pree

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1921

8. AGE: Years	Months	Days	If less than one day
24	9	7	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Howard Rodgers
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sarah Adams
15. Birthplace Balto Md

16 (a) Informant Sarah Rodgers
(b) Address 413 N Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Frederick Road

18 (a) Funeral director Mrs. Robert A. Elliott & Bro
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 11 1946

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7th 1946, at 9:57 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial pneumonia, acidosis, dehydration & mild starvation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 3-8-46

Hurtin to Wil

G37296 | BALTIMORE CITY HEALTH DEPARTMENT | 93D | Registered No. G37296

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 W. Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Janie Washington
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Henry
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 12-1-1909
8. AGE: Years 43 | Months 2 | Days 7 | If less than one day hr. min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Geo Robinson
13. Birthplace N.C.

MOTHER
14. Maiden Name Julia ?
15. Birthplace N. C.

16 (a) Informant Margret Crosby
(b) Address 839 W. Fayette St
17 (a) Shipped (Burial, cremation, or removal) (b) Date of removal 2 11 46 (month) (day) (year)
(c) Cemetery or crematory Woodmont Cem
Location Wilmington N C
18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave
19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1946, at 6 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1945 to Feb 8 1946, and that I last saw h[er] alive on Feb 8 1946

Immediate cause of death — Duration
Cardio-Vascular Disease — 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. W. Rando M. D.
Address 2445 Druid Ave Date signed 8/9/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use no abbreviations or symbols. Any

G37297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G37297
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Road
(c) Hospital or institution:
Anderson's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alsina B. Gleason

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Henry M. Gleason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1858

8. AGE: Years	Months	Days	If less than one day
87	1	27	hr. min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Magruder
13. Birthplace Unknown

MOTHER
14. Maiden Name Rebecca Zolars
15. Birthplace Ohio

16 (a) Informant Mrs. W. W. Cort
(b) Address 5000 Norwood Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb. 11, 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 11 1946

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1946 at 2 45 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Dec 9 1943 to Feb 9 1946 and that I last saw h[illegible] alive on Feb 3 1946

Immediate cause of death	Duration
Chronic Myocardial Degeneration	5 yrs.
Due to	
Due to Polycystic Kidney Right	?
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation No operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joshua H. Armacost M. D.
Address 3911 Liberty Heights Ave. Signed Feb 9 1946

X Road

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G37298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution:
West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter L. Mc Creary

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-4793

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Lula L. McCreary.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1867.

8. AGE: Years	Months	Days	If less than one day
76	6	13	hr. min.

9. Birthplace Brooklyn - N. Y.
(Town, county, and State)
10. Usual Occupation Shipping Clerk.
11. Industry or business

FATHER
12. Name James Mc Creary.
13. Birthplace Unknown - O

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. Lula L. McCreary.
(b) Address 510 N. Bruce St.

17 (a) Burial. (b) Date thereof Feb. 13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles Schumb.
(b) Address 505 N. Monroe St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/46 19 ; at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7/46 19 to 2/10/46 19 ; and that I last saw him alive on 2/10/46 19

Immediate cause of death Cardiac Failure — Duration 2 days

Due to Arteriosclerotic Cardiovascular Changes and Cardiac ?

Due to Hypertrophy

Other Conditions

Left Direct Inguinal Hernia Incarcerated

(Include pregnancy within 3 months of death)

Date of operation 2/7/46

Major findings of operation: Sliding Hernia of Sigmoid with incarcerated loop of Small Bowel. Also

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Dowkas M. D.
Address W. B. Gen. H. Date signed 2/10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Statement of information should be carefully supplied. The

G37299 ✓ G37299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1706

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Simms

3 (b) If veteran, name war: none
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Violet May Simms
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1905

8. AGE: Years	Months	Days	If less than one day
40	10	15	hr. min.

9. Birthplace: Ellicott City, Md. (Town, county, and state)
10. Usual Occupation: Electrician
11. Industry or business

FATHER
12. Name: George Simms
13. Birthplace: Towson, Md.

MOTHER
14. Maiden Name: Susan E. Peoples
15. Birthplace: North Carolina

16 (a) Informant: Mr. Ernest Simms
(b) Address: 5506 Mattfeld Ave. 9

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)
(c) Cemetery or crematory: St. John's Cem.
Location: Ellicott City, Md

18 (a) Funeral director: H.M. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 11 (Date received by Registrar) (b) 1946 Huntington Willi... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1946, at 2 15 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Prior death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Skull fracture
Intracranial hemorrhage

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15 6
(a) Date of injury 1:30 A.M. 2-9-46
(b) Where did injury occur? W. North Ave. & Poplar Grove St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Auto hit by auto

23. Signature Benedict Skotarlic M.D. Medical Examiner.
Date signed 2/9/46.

X

637300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓ 637300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address # 23 W. 27th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 W. 27th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor J Roper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1874

8. AGE: Years	Months	Days	If less than one day
71	1	21	hr. min.

9. Birthplace Norfolk Va
(Town, county, and state)

10. Usual Occupation Retired clerk

11. Industry or business C. P Phone Co

FATHER
12. Name John Roper
13. Birthplace Petersburg Va

MOTHER
14. Maiden Name Emma Edwards
15. Birthplace Petersburg Va.

16 (a) Informant Lillian J. Roper
(b) Address 23 W 27th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) FEB 11 1946 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1946, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Feb 9 1946, and that I last saw her alive on Feb 6 1946.

Immediate cause of death	Duration
Carcinoma of Breast	7 yrs.
c Metastasis to Lungs & Mediastinum	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1939 & 1942

Major findings of operation: Ca of Breast

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Frances W. Kluck

Address 715 Park Ave Date signed 2/9/46 M. D.

X

G37301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 330

Registered No. G37301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 543 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 N. Carey St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Amy Noel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Stark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1879

8. AGE: Years 66 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Northumberland Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Taylor
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Martha Taylor
15. Birthplace Northumberland Co. Va.

16 (a) Informant Stark Noel
(b) Address 543 N. Carey St.

17 (a) Burial (b) Date thereof Feb. 11, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 2 11 1946 (b) Twitington Williams, M.D.
(Date rec'd by local reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/46 19 , at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/46 to 2/8/46 and that I last saw h— alive on 2/7/46

Immediate cause of death Bronchial Pneumonia — Duration 3 Days

Antecedent Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Ellis M. D.
Address [illegible] Date 2/9/46

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G37302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmont
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #26
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Church St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ada Queeny

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mr. George Queeny
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1911

8. AGE: Years 34 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr. Charles Face
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Florence Webb
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. George B. Queeny
(b) Address 1614 Church St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director E. Schumacher
(b) Address 1401 E. Madison St.

19 (a) (Entered by registrar) (b) Registrar

FEB 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-46 1946 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1946, to 2-10 1946, and that I last saw her alive on 2-10 1946

Immediate cause of death: melanosarcoma
c generalized metastasis — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 1-19-46
Major findings of operation: Lumbar exploration
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. De Witt Peck M. D.
Address Church Home & Hospital Date signed 2-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G37303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 F. St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Thompson

3 (b) If veteran, name war no. | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1924

8. AGE: Years 21 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Baltimore Pure Rye

11. Industry or business

FATHER 12. Name Robt. Thompson.

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Irene Manning

15. Birthplace Balto. Md.

16 (a) Informant Thomas Thompson - brother

(b) Address 422 F. Street - Sparrows Pt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave.

18 (a) Funeral director C. Schimunek

(b) Address 1601 E. Madison, St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1946, at 2 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1946 to Feb. 9 1946, and that I last saw HER alive on Feb 8 1946

Immediate cause of death	Duration
Carcinoma of Posterior Naso-Pharynx	
Due to	
Due to	
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)

Date of operation Jan. 14-1946 Laboratory

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reece R. Boone, Jr. M. D.

Address University Hosp. Date signed Feb 9, 1946

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G37304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town RURAL TIMONIUM
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. S. GORDON T. PARKS, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MRS KATHARINE PARKS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 6, 1895

8. AGE: Years	Months	Days	If less than one day
51	1	4	hr. min.

9. Birthplace TIMONIUM MARYLAND
(Town, county, and state)
10. Usual Occupation SALES MANAGER
11. Industry or business

FATHER
12. Name E.F. PARKS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name JENNIE MILLENDER
15. Birthplace MARYLAND

16 (a) Informant Union Memorial Records
(b) Address 33rd & CALVERT Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Balto. Co. Md.

18 (a) Funeral director H. W. Meads & Son.
(b) Address 805 North Calvert street

19 (a) FEB 11 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 10 1946 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 16 1946 to FEB. 10 1946 and that I last saw HIM alive on FEB 10 1946.

Immediate cause of death	Duration
T.B. MENNINGITIS	
Due to PULMONARY TBC WITH HEMATOGENOUS DISSEMINATION	
Due to T.B. LEFT K.U.B. TRACT, TB EPIDYMITIS & ORCHITIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-19-46
Major findings of operation: T.B EPIDYMITIS AND ORCHITIS
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 2/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G37305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 S. Eutaw St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 846 S Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Mae Manzon

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John A Manzon
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years 27 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Williamsburg S. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hayes Tisdale
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John A Manzon
(b) Address 846 S Eutaw St

17 (a) Removal (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kingstree S C
Location South Carolina

18 (a) Funeral director Isaiah L Brown Co
(b) Address 98 W Montgomery St

19 (a) FEB 11 1946 (Date rec'd by registrar) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/1946, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1946 to 2-8 1946 and that I last saw h[illegible] alive on 2-8 1946.

Immediate cause of death	Duration
Acute Congestive Heart Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-7-46
Major findings of operation Partial Stricture Obstruction Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 903 W Franklin Date signed 2-9

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37306 — BALTIMORE CITY HEALTH DEPARTMENT — G37306

CERTIFICATE OF DEATH 1571 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME James Godwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	1	0	0 hr. 0 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Godwin
13. Birthplace Md

MOTHER
14. Maiden Name Gertrude Prince
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 2-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Balto.

18 (a) Funeral director George A. Fosley
(b) Address Holland & Fayette Sts.

19 (a) FEB 11 1946
(Date received by local registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1946 at 10 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1946 to 2-10 1946 and that I last saw him alive on 2-10 1946.

Immediate cause of death Resp. Failure

Due to Abd. distension

Due to Intestinal obstruction due to Congenital abnormality

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation 1-29, 2-4, 2-9

Major findings of operation: 1-29 Dist of bowel no gnd. 2 obstr. 2-4, 2-9 Peritonitis & Wound breakdown

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Conner, M.D.
M. D.
Address Univ. Hosp Date signed 2-11-46

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37307 ELWOOD M. DAVIS G37307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2820 Brighton St~~
(c) Hospital or institution: Sydenham Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Brighton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elwood M. Davis.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Vera Louise Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-1915

8. AGE: Years	Months	Days	If less than one day
31	0	8	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Chemical

FATHER
12. Name James Davis
13. Birthplace Savage Md.

MOTHER
14. Maiden Name Grace Lee.
15. Birthplace Savage Md.

16 (a) Informant wife
(b) Address 2820 Brighton St.

17 (a) Cremation (b) Date thereof Feb. 11-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Registrar
(Date received by registrar)

FEB 11 1946 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28-1946 to 2-8-1946, and that I last saw h_ alive on 2-8-1946

Immediate cause of death	Duration
Meningitis	2
Hyperpyrexia	
Due to Tuberculosis.	
Due to	
Other Conditions pulmonary tuberculosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron H. Full
Address Date signed 2/9/44

Myron H. Full

HAROLD IRVING SWAM

G37308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 Q

~~G37308~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 E. 34th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harold Irving Swam

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-01-6199

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha V. Swam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1890

8. AGE: Years 55 Months 11 Days 28 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Hutzler Bros. Co.

FATHER
12. Name Elmer Swam
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie Hoffacker
15. Birthplace Maryland

16 (a) Informant Mrs. Bertha V. Swam
(b) Address 826 E. 34th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12-1946 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3291 Falls Road

19 (a) FEB 1 1946 (b) Huntington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1946 at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1946 to 2-9 1946, and that I last saw him alive on 2-9 1946

Immediate cause of death	Duration
Cardiogenic Shock	1 hour
Due to Coronary Thrombosis	1 hr
Due to Chronic Coronary Disease	(?)
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Coronary Sclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin D. Johnson M. D. M. D.
Address University Hospital Date signed 2-9-46

VS 150

Approved: Robert Lee Heaton M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G37309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS E. HERONEMUS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Helen Heronemus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1884

8. AGE: Years	Months	Days	If less than one day
61	2	2	hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Samuel F. Heronemus
13. Birthplace Unknown

MOTHER
14. Maiden Name Emma Werner
15. Birthplace Unknown

16 (a) Informant Mr. John DeWit
(b) Address 1611 Park Ave.

17 (a) Burial (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by Local Registrar) FEB 11 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Feb. 9, 1946, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1946 to Feb 9 1946 and that I last saw h[illegible] alive on Feb 9 1946

Immediate cause of death	Duration
Cerebral Hemmorrhage	
Due to Hypertension	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3001 Sharon Lane Date signed 2/11/46

X

G37310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1610

G37310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. B. & H
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Henry Wolf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-7-'46

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace W. B. & H. Hospital (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Henry L. Wolf

13. Birthplace Union, N. J.

MOTHER 14. Maiden Name Rita Hoeff

15. Birthplace Balt. Md

16 (a) Informant Henry L. Wolf (Father)
(b) Address 1415 Eastern Ave (Emp. Ind.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-46. (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd Balto. Co. Md.

18 (a) Funeral director Charles S. Stiles
(b) Address 3605 Fait Ave.

19 (a) (Date received by Local Registrar) FEB 11 1946 (b) Huntington Mills Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1946, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1946, to Feb 8 1946, and that I last saw him alive on Feb. 8 1946.

Immediate cause of death Atelectasis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Silverfeld M. D.

Address West Balt. Co. Hosp. Date signed 2/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 D

G37311 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1063 Ellicot Drive
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1063 Ellicot Drive
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene J. Kraft

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Mary A. Kraft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1876

8. AGE: Years	Months	Days	If less than one day
69	7	14 13	hr. min.

9. Birthplace Baltimore County
(Town, county, and state)
10. Usual Occupation Plumber (Retired)
11. Industry or business

FATHER
12. Name John P. Kraft
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Mc Cormick
15. Birthplace ?

16 (a) Informant Mary A. Biebel (Wife)
(b) Address 1063 Ellicot Drive

17 (a) Burial (b) Date thereof Feb. 12 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ~~XXXXXXXXX~~ New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Dallas Noel
(b) Address 52 N. Morley St.

19 (a) 2-11-1946 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Feb 10 1946 and that I last saw h~~im~~er alive on Feb 9 1946

Immediate cause of death: Chronic Pulmonary Tuberculosis. — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Pluebat M.D.
Address 2320 Edmondson Ave Date signed 2/12/46
X Physician

G37312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 100B

Registered No. G37312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 N. High St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Ma loy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Carrie McCoy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1918

8. AGE: Years	Months	Days	If less than one day
28	-	21	hr. min.

9. Birthplace Hamlett, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John McCoy
13. Birthplace N.C.

MOTHER
14. Maiden Name Rosa Bell
15. Birthplace S.C.

16 (a) Informant John McCoy
(b) Address 300 N. High St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1200 Brantley Ave

19 (a) Feb 11 1946 (Date rec'd by local reg.) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 8 1946, at 2:30 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Massive pulmonary embolism
Due to Thrombophlebitis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D. Medical Examiner.
Date signed 2-9-46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

G37313 Registered No.

487253.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Stirling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Pigram

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-1902

8. AGE: Years	Months	Days	If less than one day
43	2	27	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Street cleaner.
11. Industry or business

FATHER
12. Name John Pigram
13. Birthplace Va.

MOTHER
14. Maiden Name Ghamona August
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pennsylvania ave

19 (a) (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 8 1946 at 12.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1946 to Feb. 8 1946 and that I last saw him alive on Feb. 8 1946.

Immediate cause of death	Duration
TUBERCULOSIS, PULMONARY far advanced	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dr. Adams

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Williams M. D.
Address Johns Hopkins Hosp. Date signed 2-8-46

VS 150

G37314

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 108

G37314

Reg. Dist. No. 21-7

1. PLACE OF DEATH:
City Baltimore
or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
If long in above place of death?
Hospital, institution, or street address where death occurred: route 6 Spingarn Memorial
If long in hospital or institution? Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Mechanicsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

(a) FULL NAME Wm Archie Morgan

3. (b) Social Security Number —

Sex	4. Color or race	5.(a) Single, married, widowed, or divorced
male	white	single

(b) Name of husband or wife

5.(c) If alive, give age ... years

Birth date of deceased (mo., day, yr.)

AGE: Years 1 | Months 13 | Days 6 | If less than one day ... hrs. ... min.

Birthplace Dec. 1, 1944
(Town, county, and state)

Usual occupation none

Industry or business

12. Name Joseph A. Morgan
13. Birthplace Md.
14. Maiden name Hilda Jones
15. Birthplace Md.

Informant Joseph A. Morgan
Address Mechanicsville Md.

Burial (Burial, cremation, or removal, which?) Date thereof 1/9/46 (month) (day) (year)
Cemetery or crematory Joy Chapel
Location Hollywood Md.
Funeral director R. B. Robinson
Address Leonardtown Md.

FEB 19 1946 (Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1946, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Jan 7 1946
and that I last saw him alive on Jan 7 1946

Immediate cause of death	DURATION
Acute Pneumonia	
Due to Lobar Pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

22. SIGNATURE Frank A. Carrico M. D. or other

Address Leonardtown Date signed 1/9/46

G37315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G37315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution:
Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5418 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH KAHL

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Augustine Kahl
6 (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) October 8, 1885
8. AGE: Years 60 | Months 4 | Days 1 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name — McAwee
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr. Augustine Kahl.
(b) Address 5418 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Howard N. Bliss, Jr.
(b) Address 4914 Belair Road

19 (a) FEB 11 1946 (Entered by Local Reg.) (b) Huntingtown Hillsboro Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1946, at 11:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1946, to 2/9 1946, and that I last saw her alive on 2/9 1946.

	Duration
Immediate cause of death CONGESTIVE HEART FAILURE	1 DAY
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address Madison & Linden Ave Date signed 2/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1634

Registered No. G37316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) * * *

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1659 Aisquith St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country * * *

3 (a) FULL NAME Margaret M. Neubauer

3 (b) If veteran, name war No

3 (c) Social Security Account No. 218-12-4996

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence L. Neubauer

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) Oct 6-1922

8. AGE: Years 23 | Months 4 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Bernard W Spalding
13. Birthplace Maryland

MOTHER
14. Maiden Name Etty Schultz Norton
15. Birthplace Maryland

16 (a) Informant Etta Spalding
(b) Address 4 E. 24th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB. 13-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas J. Evans Son, Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) FEB 11 1946 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-9 1946, at 1:10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to their death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon Monoxide poisoning.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 8 1946
(b) Where did injury occur? 1659 Aisquith St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Means of injury Asphyxiation due to Carbon Monoxide poisoning
Signature Benedict Shiturdie M.D. Medical Examiner.
Date signed 2-9-46

VS 151

the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G37317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37317 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Roland Avenue & Upland Road
(c) Hospital or institution: Roland Park Apartments B

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Avenue & Upland Road Roland Park (If outside Baltimore give town)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 100 Upland Rd.

3 (a) FULL NAME CHARLES EDWARD WOLLMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louise K. Wollman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1889

8. AGE: Years	Months	Days	If less than one day
56	8	4	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Treasurer
11. Industry or business Gas & Electric Co.

FATHER
12. Name Edward C. Wollman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mollie Hehl
15. Birthplace Md.

16 (a) Informant Mrs. LeRoy J. Sheats
(b) Address Severna Park

17 (a) Burial (b) Date thereof 2/14/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 11 1946 (Date rec'd by registrar) (b) Hunter Tom Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11/46 19 , at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 2/11/46

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

637318 637318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 John St.
(c) Hospital or institution: at Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 John St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mabel Alice Hudson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John S. Hudson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 4 1880

8. AGE: Years 66 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Home

11. Industry or business "

FATHER 12. Name Wm. E. Waddell
13. Birthplace Virginia

MOTHER 14. Maiden Name Ellen — ? —
15. Birthplace Virginia

16 (a) Informant Mrs. Singleton Hudson (son)
(b) Address 1508 Mosher Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-46 (month) (day) (year)
(c) Cemetery or Crematory Singleton Chapel
Location Gloucester Co. Va.

18 (a) Funeral director Sherwood Morgan Co.
(b) Address 108 W. Mt. Ave.

19 (a) — (Date rec'd by registrar) (b) Entered by Williams

FEB 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1945 to Feb. 10 1946 and that I last saw h[illegible] alive on Feb. 10 1946

Immediate cause of death — Duration
Myocardial Degeneral — 4 yrs
Due to Chr. Nephritis — 8 yrs
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Homer L. Todd M. D.
Address 2108 St Paul St. Date signed 2/11/46

X

G37319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13D

G37319 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th Street
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs 9 mos 8 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs 9 mos 8 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ann Burton Jeffers (ANNE BURTON JEFFERS)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	DIVORCED husband

6 (b) Name of husband or wife Alexander D. Jeffers

6 (c) If alive, give age years

Rhoda Dawson Mehul

7. Birth date of deceased (mo., day, yr.) August 25, 1851

8. AGE: Years	Months	Days	If less than one day
94	5	14	hr. min.

9. Birthplace Annapolis, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Nicholson Jeffers

FATHER 13. Birthplace Bridgeton, New Jersey

MOTHER 14. Maiden Name Lois Le Grand Smith

MOTHER 15. Birthplace Fort Delaware, Delaware

16 (a) Informant Home for Incurable records

(b) Address 700 W. 40th St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-46 (month) (day) (year)

(c) Cemetery or crematory U. S. Naval Cemetery

Location Annapolis Md.

18 (a) Funeral director Stewart & Mangold Co.

(b) Address 1024 North Ave

19 (a) FEB 11 1946 (Date received by registrar) (b) Huntingtown Maryland Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1946, at 11.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1940 to Feb. 9 1946, and that I last saw her alive on Feb. 9 1946.

Immediate cause of death Congestive Heart Failure — Duration 3 months

Due to Arteriosclerotic & Hypertensive Cardiac Vascular Disease — Many Years

Due to —

Other Conditions Widespread Senile Degenerative Changes — Years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Thomas Conrad Wolf, M.D.

Address 11 E. Chase St. Balto. Md. Date signed 2/10/46

G37320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G37320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Newington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Newington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Rountree

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1944

8. AGE: Years	Months	Days	If less than one day
1	7	9	hr. min.

9. Birthplace Savanah, Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Calvin Rountree
13. Birthplace Sylvania Ga

MOTHER
14. Maiden Name Mary Caudell
15. Birthplace Tarboro NC

16 (a) Informant Mary Country
(b) Address 727 Newington Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Bonaventure
Location Savanah Ga

18 (a) Funeral director Thom & Lee
(b) Address 121 E. Pratt St

19 (a) (Date received by Registrar) (b) Huntington Williams Registrar

FEB 13 1946

VS-154

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1946 at 12 Noon

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia, bilateral.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. (Medical Examiner.)
Date signed 2-11-46

X

MARVIN

3708 637321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 B Registered No. 637321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Colombia S.A. County
(b) City or town Barranquilla
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Colombia S.A.

3 (a) FULL NAME Alfred Marvin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Eva Wallis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-18-93

8. AGE: Years	Months	Days	If less than one day
52	8	22	hr. min.

9. Birthplace N.Y.
(Town, county, and state)
10. Usual Occupation Electrician.
11. Industry or business

FATHER
12. Name Chas. H. Marvin.
13. Birthplace N.Y.

MOTHER
14. Maiden Name Abbey Rudolph.
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Long Island N.Y.

18 (a) Funeral director Gilbert & Son
(b) Address 1217 Eutaw St.

19 (a) 2-13-1946 (b) Francis Tom Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Feb. 10 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1945 to 2-10 1946 and that I last saw h. alive on 2-10 1946

Immediate cause of death Mediastinal obstruction with atelectasis

Due to Giant Cell Tumor of Spindle type - left chest

Due to Sepsis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 19, 1945 Path No. 1946

Major findings of operation Feb 9 1946 Inoperable tumor in left chest

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Henry Wellman
Address Johns Hopkins Hospital Date signed Feb 13 1946

VS 150

G37322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G37322 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6212 Brook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6212 Brook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D Pippin

3 (b) If veteran, name war: World War 2

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Audrey E Pippin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8/25/18

8. AGE: Years	Months	Days	If less than one day
27	5	16	hr. min.

9. Birthplace: Kent Co Md (Town, county, and state)

10. Usual Occupation: Sargeant

11. Industry or business: U S Army

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr Chas Miller
(b) Address: 6212 Brook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Balto. City Md.

18 (a) Funeral director: Lasanka Funeral Home
(b) Address: 7401 Belair Road

19 (a) FEB 11 1946 (Date rec'd by registrar) Hunting for Wife

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946, at 8 A.M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to Atheromatous plague

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shtarelic M.D.
Medical Examiner.
Date signed 2-10-46

VS 151

Give age if expiry imporcable. Physicians: please write the causes of death clearly and legibly.

G37323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37323 Registered No. 1190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. Belair Rd & Gladeane.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Ann Ewing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/5/46

8. AGE: Years	Months	Days	If less than one day
0	1 0	35	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Nelson J Ewing
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Margaret Peacock
15. Birthplace Baltimore, Md

16 (a) Informant Nelson J Ewing
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lassahn Burying Grd
Location 7401 Belair Road

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9-1946, at 8 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8-1946, to 2-9-1946, and that I last saw h-- alive on 2-7-1946.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Pneumonia	
Due to Vomiting	1 wk
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward H Lewis M. D.
Address Date signed 2-9-46

VS 150

G37324

AB- 99086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G37324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 534 S. Pace St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Morton Lacks or Anthony Morton Lackowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13- 1902

8. AGE: Years	Months	Days	If less than one day
43 42	1	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vincent Lackowitz
13. Birthplace Lithuania

MOTHER
14. Maiden Name Rose
15. Birthplace Lithuania

16 (a) Informant Baltimore City Hospitals(Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles W. Kachourian
(b) Address 703 McHenry St.

19 (a) FEB 11 1946 Huntington for Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8- 1946, at 4.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1946, to 2-8- 1946, and that I last saw h im alive on 2-8- 1946

Immediate cause of death	Duration
Lobar Pneu Left lung	
Due to Organism unknown	
Due to	
Other Conditions Delirium tremens Chronic alcoholism.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jorrigor M. D.
Address Baltimore City Hall Date signed 2-9-46

X

G37325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G37325 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument Street
(c) Hospital or institution:
Sinai Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Bal. Md.
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Durham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Richardson Joseph W. Richardson Jr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1939

8. AGE: Years	Months	Days	If less than one day
6	6	6 10	###### Hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Joseph W. Richardson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence E. Wagner
15. Birthplace Maryland

16 (a) Informant Joseph W. Richardson
(b) Address 1525 NDurham Street

17 (a) Burial (b) Date thereof 2/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore, ##
Location E. North Avenue
18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue
19 FEB 11 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1946 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1946, to 2/9 1946, and that I last saw h- alive on 2/9 1946

Immediate cause of death Cardio respiratory failure — Duration

Due to Leukemia? Cerebral hemorrhage?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Deferred until necessary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Rudo M. D.
Address Sinai Hosp. Date signed 2/9/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Hunting to William

G37326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37326 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Grindall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Grindall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie A. Finan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8-1870

8. AGE: Years ? 75 | Months 5 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Patrick J. Finan
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary C. Gaffy
15. Birthplace Ireland.

16 (a) Informant Mrs Lillian A. Fortunann
(b) Address 405 Fleone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1117 Light St.

19 (a) (Date received by local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1946, at 9.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 8 1946 and that I last saw h[illegible] alive on Feb 8 1946.

Immediate cause of death Myocardial Insufficiency — Duration

Due to —

Due to —

Other Conditions Arteriosclerosis, Hypertension, Emphysema

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Fortunann

Address 1337 S. Charles St. Date signed 2/11/46

VS 150

G37327 G37327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 Druid Hill Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Marie L. Tilley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife Benjamin Tilley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1900

8. AGE: Years	Months	Days	If less than one day
45	10	29	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Burrus
15. Birthplace Md.

16 (a) Informant Jessie L. Tilley
(b) Address 2521 Druid Hill Ave

17 (a) Burial (b) Date thereof Feb. 12, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director John H. Johnson
(b) Address 1744 Druid Hill Ave.

19 (a) FEB 11 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8" 1946, at 3 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to 2-8- 1946, and that I last saw her alive on 2-8 1946.

Immediate cause of death	Duration
Hypertensive Cardio Vascular - Renal	
Due to R. F. Humphreys	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy R. F. Humphreys - Cardiac Infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2037 Eutaw Pl. Date signed Feb 8 1946

VS 3

G37328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194 Q

G37328 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flint St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 286 Park ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph R. Taylor Sr

3 (b) If veteran, name war W

3 (c) Social Security Account No. 218-20-1510

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
	70			hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation Attorney
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant L C Thomas
(b) Address Calvert Bldg Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/46 (month) (day) (year)
(c) Cemetery or crematory Brownsville
Location Brownsville Tenn.

18 (a) Funeral director Wilson Coffee
(b) Address 1217 E Cant Ave

19 (a) 1946 (Date filed by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946, at 1 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gardner M.D. (Medical Examiner)
Date signed Feb 11 1946

G37329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37329 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5014 Benmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5014 Denmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Weinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ray Nee Sykes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1877

8. AGE: Years 68 | Months 7 | Days 15 | If less than one day ____hr. ____min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Merchant

FATHER
12. Name: Morris Weinberg
13. Birthplace: Russia

MOTHER
14. Maiden Name: Semma Shalawitz
15. Birthplace: Russia

16 (a) Informant: Morris Caplan
(b) Address: 3411 Lynchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 12, 1946 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Hebrew Cem
Location: Belair Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) Filed FEB 13 1946 (Date received by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1946 at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1946 to 2/10 1946 and that I last saw h[illegible] alive on 2/10 1946.

	Duration
Immediate cause of death: Acute Bronchopneumonia	
Due to: Ch. Myocarditis	
Due to: Acute Appendicitis Perforated	
Other Conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ch. Hamaten M. D.

Address 733 August St Date signed 2/11/46

VS 180

G37330 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G37330
Registered No.

CERTIFICATE OF DEATH 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County
(c) City or town Tipton (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eldon C. Ebert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-37

8. AGE: Years	Months	Days	If less than one day
8	6	15	hr. min.

9. Birthplace Ind. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Harry Ebert
13. Birthplace Mich.

MOTHER
14. Maiden Name Pearl Astrem
15. Birthplace Ind.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-46 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Tipton Ind.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1700 Eutaw Pl.

19 (a) Filed by registrar (b) Clinton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1946 at 12 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1946 to Feb 11 1946 and that I last saw him alive on Feb 11 1946 -

Immediate cause of death	Duration
Pulmonary edema	Immediate
Due to Operation	
Due to	
Other Conditions Pulmonary Stenosis 8 yrs.	

(Include pregnancy within 3 months of death)
Date of operation 2-11-46
Major findings of operation Pulmonary Stenosis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address Date signed 2-11-46

VS 150

PRESS WELL FLAINED, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G37331 ✕ ✓ G37331

484857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Liberty
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D. #2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Edward Crawford.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male.	white	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-20-24.

8. AGE: Years	Months	Days	If less than one day
21.	9	20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Banking.
11. Industry or business

FATHER
12. Name Alonzo L Crawford
13. Birthplace Md.

MOTHER
14. Maiden Name Viola Bell Alexander
15. Birthplace Md.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westview Cemetery
Location Liberty Md.

18 (a) Funeral director John D Mitchell & Son
(b) Address 4900 Eastern Ave.

19 (a) (b) Clinton Williams, M.D.
(Date rec'd by registrar) Registrar

FEB 12 1946

US-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-10 1946 at 940 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-15 1945 to Feb-10 1946 and that I last saw him alive on Feb-10 1946

Immediate cause of death	Duration
Peritonitis General	1 day
Due to Pelvic Abscess	2 days
Due to Anastamosis Large & Small Bowel	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1/14/46 & 2/10/46
Major findings of operation: Negative 1/14/46 - Peritonitis 2/10/46
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. O'Connor M.D.
Address Johns Hopkins Hosp. Date signed 2/10/46

1

G37332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G37332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3233 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3233 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE LESTER

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles H. Lester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	29	hr. min.

9. Birthplace Huntsville, Ala.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Cardwell
13. Birthplace Ala.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Wm. F. Jureit
(b) Address 3233 Belair Rd.

17 (a) Removal (b) Date thereof 2/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maple Hill Cem.
Location Huntsville, Ala.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 FEB 12 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1946 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Feb. 11 1946 and that I last saw h[illegible] alive on Feb. 9 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. J. Stevens M.D.
M.D.
Address 3700 Erdman Ave Date signed 2/11/46

G37333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G37333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Cardiff (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary E Dicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Thomas H. Dicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1872

8. AGE: Years	Months	Days	If less than one day
73	6	4	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John T. Jones
13. Birthplace Wales

MOTHER
14. Maiden Name Susan Poff
15. Birthplace Pennsylvania

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15 1946 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location Delta Pa.

18 (a) Funeral director Hubert P. Harkins
(b) Address Delta Pa.

FEB 13 1946 (Date rec'd by registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946 at 3 07 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to Feb. 12 1946, and that I last saw her alive on Feb. 12 1946.

Immediate cause of death Coronary occlusion — Duration 3 days

Due to Hypertensive cardiovascular disease

Due to

Other Conditions Post operative appendectomy with wound infection

(Include pregnancy within 3 months of death)

Date of operation Jan. 22, 1946

Major findings of operation: Acute appendicitis with perforation and abscess formation

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Cameron Montgomery Jr. M.D.
Address Union Memorial Hospital Date signed 2/12/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

G37534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmont
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Sparrows Pt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 F St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Harry Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No. 218 10 6516

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anastasia Snyder
6 (c) If alive, give age yrs years

7. Birth date of deceased (mo., day, yr.) March 21, 1890

8. AGE: Years	Months	Days	If less than one day
55 yrs.	10	20	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business

FATHER
12. Name Harry Snyder
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Emma Wagner
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Harry Snyder
(b) Address 618 F St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL RD.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) (b) Registrar

FEB 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1946, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1946 to 2-9 1946, and that I last saw him alive on 2-10-46 1946

Immediate cause of death Respiratory failure — Duration

Due to Carcinoma of lung involving auricle of heart

Due to

Other Conditions Shock

(Include pregnancy within 3 months of death)
Date of operation 2-8-46
Major findings of operation: Carcinoma of lung involving heart
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. DeWitt Peck M. D.
Address Church Home & Hospital Date signed 2-10-46

X

637335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 Q 637335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST JOSEPH HOSP. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 CLAIRMONT ST.
(If rural give location)
(e) Citizen of foreign country? Clairemont (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Eva [illegible] Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife EVA GROSS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 24 1893

8. AGE: Years	Months	Days	If less than one day
52	11	10	hr. min.

9. Birthplace STEELTON PENNA. (Town, county, and state)
10. Usual Occupation AUTOMOBLIE
11. Industry or business MECHANIC

FATHER
12. Name PHILLIP GROSS
13. Birthplace PENNA.

MOTHER
14. Maiden Name ANNA LICHTY
15. Birthplace PENNA.

16 (a) Informant EVA GROSS (WIFE)
(b) Address 3505 CLAIRMONT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 14/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1946 at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1946 to 2-10 1946, and that I last saw h[illegible] alive on 2-10 1946

Immediate cause of death [illegible]

Duration

Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-9-46

Major findings of operation: [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1400 N. Caroline Date signed 2-10-46

VS 150 FEB 12 1946

G37336

10-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G37336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Bureau St
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto: Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 E. Chase St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Eichelberger EGGENSPERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/(1875)

8. AGE: Years	Months	Days	If less than one day hr. min.
65	10	11	24 6 80

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Rose Davis
(b) Address 908 E Chase St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo FEB 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 12 1946 (Date rec'd by registrar) (Operating Officer) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1946, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1946 to 2/2 1946, and that I last saw [illegible] alive on 2/2 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis	9 days
Due to	
Due to Cardiac failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. MacMurchy
Address 801 Bureau St Date signed 2-11-46

3287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37337 — BALTIMORE CITY HEALTH DEPARTMENT — G37337

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 N. Green Street
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N. Green Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Dushane

3 (b) If veteran, name war: ###
3 (c) Social Security Account No. 212-16-5177

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1864

8. AGE: Years	Months	Days	If less than one day
81 82	1	18	hr. min.

9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Mercantile Trust Co.

FATHER
12. Name John Henry Dushane
13. Birthplace Washington D. C.

MOTHER
14. Maiden Name Minerva Reese
15. Birthplace Washington D. C.

16 (a) Informant Mr. C. H. Schantz
(b) Address 1605 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Congressonal
Location Washington D. C.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by reg.) FEB 12 1946 (b) Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/46 19 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940 to 2/10 1946 and that I last saw him alive on 2/9 1946.

Immediate cause of death	Duration
Myocarditis	Gradual
Due to Arterio Sclerosis	
Due to Chronic Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Beasley M. D.
Address 1403 Park Ave. Date signed 2/14/46

Entering for Hillsman

G37338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37338 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 N. Kennard Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Kennard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella Virginia Honaei

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1864

8. AGE: Years 81 | Months 11 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Crowther
13. Birthplace England

MOTHER 14. Maiden Name Susan Johnson
15. Birthplace Alexandria Va.

16 (a) Informant Ella H. Elkins
(b) Address 113 N Kennard Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Nelson Colvin
(b) Address 1217 E Pratt St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1946 to Feb 11 1946, and that I last saw h w alive on Feb. 10 1946

Immediate cause of death: Cerebral Thrombosis — Duration: 2 days
Myocardial degeneration — Several years
Due to: Arterio-sclerosis — Many years
Due to: —
Other Conditions: Hypostatic Pneumonia — 2 days
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature A. F. Rio M. D.
Address 24 S. Broadway Date signed Feb 11/46

FEB 15 1946 Leighton Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G37339 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Presstman st
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Presstman st (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel P. Kelson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Thomas E. Kelson

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 2-2-1901

8. AGE: Years 45 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Phil. Handey

13. Birthplace Md.

MOTHER 14. Maiden Name Bertha ward

15. Birthplace Md.

16 (a) Informant Thomas E. Kelson

(b) Address 1303 Presstman st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director John M. Johnson

(b) Address 1700 Druid Hill Ave

19 (a) FEB 12 1946 (Date rec'd by registrar) (b) Huntington Willie [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-46 19..., at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1946, to 2-8- 1946 and that I last saw h.. alive on 2-7- 1946.

Immediate cause of death Hypertensive Heart — Duration 6 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George C Page M.D.
Address 516 N. Monroe St Date signed 2-12-46

G37340 ✓ G37340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 771 Registered No.

1. PLACE OF DEATH: 601 N. Bentalou St.
(a) Baltimore City, Maryland
(b) Street address 601 N. Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Oliver Harrison

3 (b) If veteran, name war None

3 (c) Social Security Account No. 216-05-2508

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 29, 1903

8. AGE: Years 43 | Months 10 | Days 11 | If less than one day hr. — min.

9. Birthplace Frederick Md.
(Town, county, and state)

10. Usual Occupation Steel Lasser

11. Industry or business Glenn L. Martin Co.

FATHER 12. Name Charles W. Harrison

13. Birthplace Frederick Md

MOTHER 14. Maiden Name Chrissie Grove

15. Birthplace Frederick Md.

16 (a) Informant Chrissie Harrison

(b) Address 601 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Md.

18 (a) Funeral director George Weber & Son

(b) Address 2513 Edmondson Ave.

19 (a) Filed FEB 12 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Feb 10 1946 and that I last saw h— alive on Feb 10 1946

Immediate cause of death Pneumonia

Due to Acute Nephritis

Due to Chronic Alcoholism

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard T. Emrich

Address 2379 Aisquith Date signed 2/10/46 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

37341 ✓ G37341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 75B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 S. Plainview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Sacca

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.) 5-13-40

8. AGE: Years	Months	Days	If less than one day
5	8	4/13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Paul Sacca.
13. Birthplace Italy

MOTHER 14. Maiden Name Lucia Pirruccillo
15. Birthplace Italy

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2-12-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Road

18 (a) Funeral director Joseph Fracce Inc.
(b) Address 2013 Belmont Ave.

19 (a) 2-9-1946 (b)
(Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9-1946, at 7:51 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1946 to 2-9 1946 and that I last saw h. alive on 2-9-1946.

Immediate cause of death	Duration
Coolies Anemia + Splenectomy	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-6-46
Major findings of operation: enlarged Spleen
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Palmer
Address Johns Hopkins Hosp. Date signed 2-11-1946

(OVER)

G37342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G37342

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisterstown & Gwynn Sts.
(c) Hospital or institution: University Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Sewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Laurence Sewell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1896

8. AGE: Years 49 | Months 9 | Days 27 | If less than one day: hr. min.

9. Birthplace Prince Frederick Md.
(Town, county and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Duke
13. Birthplace Prince Frederick Md.

MOTHER
14. Maiden Name Edith Tabb
15. Birthplace Prince Frederick Md.

16 (a) Informant Edith Sewell
(b) Address 1627 W. Franklin St.

17 (a) Burial (b) Date thereof Feb. 14 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.
FEB 12 1946 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1946 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7/46 19 to 2/10 1946, and that I last saw he alive on 2/10 1946.

Immediate cause of death Uremia — Duration

Due to Chronic Glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Bowe
Address Univ. Hosp. Date signed 2/12/46
M D

VS 150

G37343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13B

G37343

Reg. Dist. No.

PLACE OF DEATH:
City Baltimore
or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Length in above place of death? 12 yrs.
Hospital, institution or street address where death occurred: 4805 Halethorpe Ave.
Length in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Govans #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

(1) FULL NAME Augustus Shaw.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White.	Widowed.

(b) Name of husband or wife Mary Shaw.

(c) If alive, give age ... years

7. Date of death (mo., day, yr.) March 27. 1870

AGE:	Years	Months	Days	If less than one day
	75	10	12	hrs. min.

8. Birthplace Long Island. N.Y.
(Town, county, and state)
9. Usual occupation Shoredore Shecker
10. Industry or business Fruit Grower
11. Name Augustus Shaw.
12. Birthplace Long Island. N.Y.
13. Maiden name Sarah Garretson
14. Birthplace New York.
15. Informant John Twitchman
16. Address Govans #1.
17. Burial, cremation, or removal. Which? Burial. Date thereof February 12, 1946 (month) (day) (year)
18. Cemetery or crematory Mt. Olivet Cem.
19. Location Frederick Md.
20. Funeral director Reginald F. Hoppel
21. Address 312 E. Fayette St. Baltimore Md.
Date filed with Registrar FEB 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9. 1946 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1946 to Feb. 9. 1946 and that I last saw him alive on Feb. 9. 1946

Immediate cause of death: Pulmonary tuberculosis

DURATION: over 4 months

Due to: with - lung collapse - 4 days.

Due to: associated with arteriosclerosis. 5 yrs.

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis N. Sollin M.D.
M. D. or other
Address Parsons Rx. md Date signed 2/19/46

G37344 — BALTIMORE CITY HEALTH DEPARTMENT — G37344

CERTIFICATE OF DEATH

47D ✓ — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home
(c) Hospital or institution 3128 Clarmont Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dello;
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 Clarmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter W Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5142

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1891

8. AGE: Years	Months	Days	If less than one day
54	7	20	hr. min.

9. Birthplace Cambridge Md.
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Salis Fleming
13. Birthplace Ireland

MOTHER
14. Maiden Name Mollie Butler
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Fleming
(b) Address 3728 Clarmont Ave

17 (a) Burial (b) Date thereof 2/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS Form 1a FEB 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/ 1945, to 2/10 1946, and that I last saw h[illegible] alive on 2/9 1946.

Immediate cause of death Primary Ca of Lung — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank V. Maniere M. D.

Address 333 S. Eden St. Date signed 2/11/46

X Maniere

G37345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G37345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3434 Lyndale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3434 Lyndale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLA WRIGHT DIGGS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Henry K. Diggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1838

8. AGE: Years	Months	Days	If less than one day
77	2	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Matthew Wright
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna E. Purvis
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elinor Shaffar
(b) Address 3434 Lyndale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-43 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS,
(b) Address NORTH AVE. & BROADWAY

16 (c) FEB 12 1946 (Date rec'd by registrar) (d) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1943, at 8.10 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1943 to Feb 11 1943 and that I last saw h[illegible] alive on Feb. 5 1943.

Immediate cause of death	Duration
Cardiac Asphyxia	9 m.
Cerebral Embolism	
Due to Arteriosclerosis	
Coronary Thrombosis	5 yrs.
Due to Chronic Hypertension	
Other Conditions Bilateral Cataracts	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? Inc. (Specify type of place)
(e) Means of injury
23. Signature Harry Hyde
Address 1100 E. North Ave. Date signed 2/11/43 (M. D.)

VS 150

X

G37346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37346 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~4113 Sargeant St.~~
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Sargeant St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Lemmon (Lemmon)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-0546

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	(married)

6 (b) Name of husband or wife Emma Lemmon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1879

8. AGE: Years	Months	Days	If less than one day
67	0	10	hr. min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business Linen Thread Co.

FATHER
12. Name William T. Lemmon
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Theresa Miller
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Emma Lemmon
(b) Address 1314 Sargeant St.

17 (a) Burial (b) Date thereof 2/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11-46 19

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31-46 to 2-11-46; and that I last saw him alive on 2-11-46

Immediate cause of death Pulmonary Embolism — Duration

Due to

Due to

Other Conditions Fractured Patella
(Include pregnancy within 3 months of death)

Date of operation 2-1-46

Major findings of operation: Fractured Patella

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1-31-46 at 21/2 M
(c) Where did injury occur? Baltimore
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? on street While at work? No
(Specify type of place)
(e) Means of injury Fractured Patella

23. Signature
Address South Balto. Gen'l Hosp. Signed 2-11-46 M. D.

Howard J. Williams, M.D.

Howard J. Williams, M.D.

A37347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G37347 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the te the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 Arunah Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ELIZABETH HEINZE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William T. Heinze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	2	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stoll
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Marie Heinze
(b) Address 2419 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 12 1946 Jos. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1946, at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1946 to Feb 12 1946
and that I last saw alive on Feb 11 1946

Immediate cause of death Arteriosclerotic Heart Disease — Duration
Due to Bronchopneumonia — 2 days
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Strahl M.D.
Address 230 E. Lafayette Ave Date signed 2/13/46

93D

G37348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G37348 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 S. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Patrick McCann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Emma G.
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business B. & O. R.R. Retired

FATHER
12. Name James P. McCann
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs Gladys Galinsky
(b) Address 226 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1200 W. Lombard St.

19 (a) FEB 12 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Feb 1946, and that I last saw h[illegible] alive on Jan 19 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Hypertensive Cardio Vascular Renal Disease	
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Shorofsky M.D.
Address 601 N. Monroe St Date signed 2/11/46

VS 150

G37349

TH. 98799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

G37349 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Ostend St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Burgess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Seperated

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6th 1901

8. AGE: Years	Months	Days	If less than one day
45	0	3	hr. min.

9. Birthplace S. C (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Peter Burgess
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Black
15. Birthplace S.C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-46 (month) (day) (year)
(c) Cemetery or crematory Lake City
Location South Carolina
18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.
19 (a) (Date rec'd by reg'r) (b) Huntington Williams Mortuary

FEB 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9th 1946 19 at 9.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25th 19 46 to Feb. 9 19 46 and that I last saw h im alive on Feb. 9th 19 46

Immediate cause of death Bacteremia — Duration 2 Days
Due to Acute urinary retention — 4 wks
Due to Urethral stricture — 1 yr ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1-25-46
Major findings of operation: as a Gould
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Orth M. D.
Address Balto City Hosp Date signed 2-9-46

X

G37350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

G37350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 651 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 651 George St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Ann Conquest

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Onocock Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Harriett Gaines
(b) Address 651 George St

17 (a) Burial (b) Date thereof 2-13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Edmondson Ave.

19 (a) FEB 12 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1946, at 5.09 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1945 to 2-9 1946 and that I last saw h[illegible] alive on 2-8 1946

Immediate cause of death: Cardio Vascular Renal Disease — Duration 2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 554 Dolphin St Date signed

VS 150

G37351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. G37351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Warner St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Strawberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 6, 1905

8. AGE: Years: 40 | Months: 11 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: George Mason
13. Birthplace: Wash. D.C.

MOTHER
14. Maiden Name: Josephine Bernard
15. Birthplace: Virginia

16 (a) Informant: Josephine Mason
(b) Address: 932 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-46 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location

18 (a) Funeral director: Adolphus Holsteak
(b) Address: 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1946 at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Subdural Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 22/2

(a) Date of injury Feb 9 at 9 1946 M.
(b) Where did injury occur? 609 Warner St
(c) Did injury occur at home, on farm, industrial place, in public place? at home – While at work? No
(d) Means of injury Fell down stairs

23. Signature: Benedict Skitarelic M.D. (Medical Examiner.)
Date signed 2-10-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G37352 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital W 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4512 Springdale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Heimiller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June [illegible] 1868

8. AGE: Years 77 | Months 7 | Days 12 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William Heimiller
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Barthea Heimiller
(b) Address 4512 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 14/1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Harry N. Armacost
(b) Address 4204 Edgewood Ave

19 (a) (b) Date rec'd by Registrar FEB 12 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1946, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1946, to 2/11 1946, and that I last saw he alive on 2/11 1946

	Duration
Immediate cause of death Cardiac failure	
Due to Cerebral Collapse	
Due to Gallbladder cystic & Shock	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Baggett M.D.
Address University Hosp Date signed 2/11/46

G37353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/110a

G37353

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Jewish Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 Foster Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Cudnick CUONIK

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-05-4374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1883

8. AGE: Years	Months	Days	If less than one day
62	6	13	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Supervisor
11. Industry or business Chas B. Silvers

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs Mary Cudnik
(b) Address

17 (a) Burial (b) Date thereof 2/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director J Neuman & Son
(b) Address 3 x S Broadway

19 (a) (b)
(Date received by Registrar) Registrar

FEB 12 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11 19 46 at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 19 46 to 2-11 19 46 and that I last saw h alive on 2-11 19 46.

Immediate cause of death	Duration
Coronary occlusion	
Due to thrombosis and fracture	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L Rowland M. D.
Address Emerg (Hospital) Date signed 2-11-46

X

G37354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

G37354 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Mayfield av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Mayfield av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Murphy

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 214-20-1875

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christina M. Murphy
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Sept 8, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	3	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Retired Police
11. Industry or business

FATHER
12. Name: Patrick Murphy.
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Catherine Lacey.
15. Birthplace: Unknown.

16 (a) Informant: Christina M. Murphy.
(b) Address: 2816 Mayfield av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 14, 46 (month) (day) (year)
(c) Cemetery or crematory: Loreland Memorial Park
Location: Taylor av

18 (a) Funeral director: S. Walter Mayo
(b) Address: 619 N. Bouldin St, Balto. Md.

19 (a) (Date rec'd by reg.) FEB 12 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11, 1946, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Feb 11 1946 and that I last saw him alive on Feb 10 1946

Immediate cause of death: Pulmonary Embolism — Duration

Due to: Hypertensive Cardiovascular Renal Disease

Due to:

Other Conditions: Senile Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Robert A. Kilpatrick M. D.
Address: 345 Walbrook Av Date signed: 2/12/46

Form approved, Health Department, Baltimore City. Entry must be complete, using ink or typewriter. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Omit all unnecessary words. Be sure to state correct age in especially important.

G37355 G37358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 S. Oldham St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 S. Oldham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julian H. Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sadie Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1888

8. AGE: Years	Months	Days	If less than one day
57	2	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Continental Can Co.

FATHER
12. Name William Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie Hessenauer
15. Birthplace Maryland

16 (a) Informant Mrs. Sadie Taylor
(b) Address 712 S. Oldham St.

17 (a) Burial (b) Date thereof 2/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

FEB 12 1946

Vs 430

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1946, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1945 to 1/10 1946, and that I last saw h[illegible] alive on 1/9 1946.

Immediate cause of death Asphyxiation
Streptococcus Bacteria
due to Decubitus.

Duration 2 Wks

Due to

Due to

Other Conditions.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mitchell F. Hunterman M. D.

Address 1076 S. East Ave Date signed 2/11/46

Huntington Williams Inc

X

G37356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37356

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2852 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2852 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Ambrose Hendrix

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3813

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora Hendrix
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1881

8. AGE: Years	Months	Days	If less than one day
64	10	6	hr. min.

9. Birthplace New Freedom, Pa. (Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business Baltimore Transit Co.

FATHER
12. Name John W. Hendrix
13. Birthplace Penna.

MOTHER
14. Maiden Name Jennie McCubbins
15. Birthplace Penna.

16 (a) Informant Mrs. Cora Hendrix
(b) Address 2852 Harlem Ave. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) FEB 12 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1946, 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943 to Feb. 10 1946 and that I last saw (him) alive on Feb. 9 1946

Immediate cause of death Arteriosclerotic C-V disease — Duration 3 yrs

Due to

Due to

Other Conditions Bronchostasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Stemmer M. D.
Address 1402 E. Lanvale St. Date signed 2-11-46

VS 150

Huntington Williams, M.D.

G37357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 55E

Registered No. G37357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Wilson St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Wilson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Violet Reynolds Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Freeman Oliver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1910

8. AGE: Years 35 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Atlanta Ga. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Arthur Reynolds
13. Birthplace Ga.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Irene Oliver
(b) Address 400 Wilson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Wm. Gorsuch & Edmondson
(b) Address 1129 N. Carlin St

19 (a) Date received by Registrar FEB 12 1946

Huntington Undertaking

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1946, at 1130 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1946 to Feb 8 1946 and that I last saw her alive on Feb 8 1946

Immediate cause of death	Duration
Cardiac failure	
Due to → Probably	
Due to Malignancy - 2	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Dr. Herman Beidel M. D.
Address 2404 Eutaw Pl Date signed 2/11/46

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

X 17

G37358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G37358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Ramsay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Ramsay St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Joseph F. Deppe Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Louisa Deppe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16-1870

8. AGE: Years 75 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Tailor

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joseph F. Deppe Jr.
(b) Address Silver Spring Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road: Balto. Md

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Maryland

19 (a) FEB 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1946, at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to Feb 9 1946, and that I last saw h[illegible] alive on 2/9 1946

	Duration
Immediate cause of death: Carcinoma of Prostate	2 yrs
Due to	
Due to	
Other Conditions Arteriosclerotic C.V disease	4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. J. Sabrinske

Address 5217 Bennett Pl Date signed 2/13/46

G37359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓160C

Registered No. G37359

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Kemp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Newborn			hr. 5 min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical Schoo FEB 11 1946
Commissioner of Health

18 (a) Funeral director.....
(b) Address.....

Commissioner of Health Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1946 at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 15 4 A M.
(b) Where did injury occur? 1110 E. Baltimore St
(c) Did injury occur at home, on farm, industrial place, in public place? [illegible] While at work? No
(d) Means of injury Asphyxia from umbilical cord

23. Signature Robert Le Fretois M.D.
Medical Examiner.

Date signed 2-8-46

5292 X

G37360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registration No. G37360

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1802 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle M. Schueler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry M. Schueler
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec 3, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	6	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at Home

FATHER
12. Name Wm Nenker
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Conway
15. Birthplace Maryland

16 (a) Informant Mrs Henry Schueler
(b) Address 1802 S Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/46 (month) (day) (year)
(c) Cemetery or crematory Maryland Mem.
Location Taylor Ave

18 (a) Funeral director John F Denny Inc
(b) Address 711 Light St.

19 (a) (Date received by Registrar) (b) Registrar

FEB 12 1946 Lucien Williams, M.D.

Vs 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9th 1946, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Feb 9 1946, and that I last saw h. alive on Feb 9 1946

Immediate cause of death	Duration
Carcinoma (Inflamatory)	4 mos.
Due to right Breast	
Due to	
Other Conditions Generalized Metastases	2 mos

(Include pregnancy within 3 months of death)

Date of operation Mar 1945

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Nulle M.D. M. D.
Address 1211 N Charles Date signed 2/11/46

X

G37361

AB-98172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G37361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos- 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Renoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27- 1877

8. AGE: Years	Months	Days	If less than one day
68	2	6	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis J. Renoff
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Maxwell
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3- 1946, at 12-30 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 2-3- 1946, and that I last saw h 2X alive on 2-3- 1946.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Davis, M.D.
Address Date signed 2-8-46

VS 150

3293

X

G37362

AB- 98134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1938

G37362

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos-4days
(e) Length of stay in Baltimore (yrs., mos., or days) 1mos-11days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrs
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Everhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26-1855

8. AGE: Years 90 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred Everhart (D)
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah ? (D)
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo FEB 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 12 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.
Registrar

3294

VS 150

X

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2- 1946, at 1AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1945 to 2-2- 1946, and that I last saw h im alive on 2-2- 1946

Immediate cause of death Bronchopneumonia — Duration 3

Due to Cerebral Hem. Acc — ?

Due to ASHD — ?

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Hopkins
Address B.C.H. Date signed 2/12/46

G37363 G37363

BALTIMORE CITY HEALTH DEPARTMENT

AB- 57041

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs. 6mos. 29days
(e) Length of stay in Baltimore (yrs., mos., or days) 54yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9- 1889

8. AGE: Years	Months	Days	If less than one day
56	6	22	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Factory Work

11. Industry or business

FATHER 12. Name ? Miller

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name Annie ?

MOTHER 15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Record)

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Locat Johns Hopkins Medical School FEB 12 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 FEB 12 1946 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31- 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2- 1940, to 1-31- 1946, and that I last saw h 9F alive on 1-31- 1946

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to	
Due to	
Other Conditions Diabetes Mellitus, Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jonathan Howland M. D.

Address B. C. H. Date signed 2/4/46

3295 8313

VS 150

G37364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 118

G37364
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden and Madison
(c) Hospital or institution:
Md. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 day
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie M. Carruthers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Nelson B. Carruthers
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) April 13, 1895

8. AGE: Years	Months	Days	If less than one day
50	9	28	hr. min.

9. Birthplace Norwalk, Conn.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George St. John
13. Birthplace Norwalk, Conn.

MOTHER
14. Maiden Name Lula Kellogg
15. Birthplace Prarie Center, Ill.

16 (a) Informant Mr. Nelson B. Carruthers
(b) Address 5100 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Funeral Home
(b) Address 4540 Liberty Heights Ave. Baltimore, Md.

19 (a) (Date received by registrar) (b) Registrar

FEB 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1946, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1946, to 2/11 1946, and that I last saw h[illegible] alive on 2/11 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Post operative abdomen	
Due to Pylorus obstruction	
Other Conditions Huntington chorea	

(Include pregnancy within 3 months of death)
Date of operation 1/28/46
Major findings of operation: Obstruction @ pylorus end of Stomach; generalized peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Gerard E. Crane M. D.
Address Md. General Hospital Date signed

Crane X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37365 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lt Irvin Miller

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Lucy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1859

8. AGE: Years 86 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name William T Miller
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth A Judge
15. Birthplace Md

16 (a) Informant Mrs L Miller
(b) Address 2315 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Mt Lawn Md

18 (a) Funeral director William Lodge
(b) Address 1217 Eutaw St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 12 1946 Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1941 to Feb 10 1946 and that I last saw him alive on Feb 2 1946

Immediate cause of death	Duration
Acute pulmonary Edema	1 day
Due to Arteriosclerotic heart disease: Symptoms	5 years
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis P. Thumberger M. D.
Address 1207 Eutaw Pl. Date signed 11-12-46

X

637366 MATHIAS + ✓ 637366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution: Church Home & Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MAZIE MATHIAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: JAMES MATHIAS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1894

8. AGE: Years 51 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home

FATHER 12. Name George W. Miles

13. Birthplace Maryland

MOTHER 14. Maiden Name Anna Warten

15. Birthplace Maryland

16 (a) Informant Mazie Mathias

(b) Address Mt. Airy, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)

(c) Cemetery Oak Grove

Location Glenwood Md.

18 (a) Funeral director C. Harry Weber

(b) Address Sykesville Md.

19 2/13 1946 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 12 1946, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1946, to 2-12 1946, and that I last saw her alive on 2-12 1946.

Immediate cause of death	Duration
ACUTE HEPATITIS	
Due to	
Due to	
Other Conditions CHRONIC CHOLECYSTITIS ABDOMINAL ADHESIONS.	

(Include pregnancy within 3 months of death)

Date of operation 2-9-46 (CHOLECYSTOSTOMY)

Major findings of operation: CHRONIC CHOLECYSTITIS T. CHOLELITHIASIS

of autopsy HEPATITIS; CHRONIC CHOLECYSTITIS.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B Leatherwood M. D.

Address Church Home & Hospital Date signed 2-12-46

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G37367

~~G37367~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 N. Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 Greenmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. T. Mitchell

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1873

8. AGE: Years	Months	Days	If less than one day
73	0	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired Stone Cutter
11. Industry or business

FATHER
12. Name George R. Mitchell
13. Birthplace unknown

MOTHER
14. Maiden Name Mary C. Strayler
15. Birthplace unknown

16 (a) Informant Nephew John W. Schukraft
(b) Address 1715 East 25th Street

17 (a) burial (b) Date thereof 2/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 2-13-1946 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1946 at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Feb 12 1946
and that I last saw he alive on Feb 11 1946.

Immediate cause of death Myocardial Insufficiency — Duration 2 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thom E. Nelson M.D.
Address 3 W. Biddle St. Date signed 2-14-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. G37368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Roland Ave & Somerset
(c) Hospital or institution: Keithley Villa
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Ave - Somerset Rd 4201 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Alice McBride Warden

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-29-1857

8. AGE: Years 88 | Months 3 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Hugh Warden
13. Birthplace Md.

MOTHER
14. Maiden Name Alice McBlair
15. Birthplace Md.

16 (a) Informant Miss Mary R. McGaw
(b) Address 1012 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Elwood Morgan Co.
(b) Address 108 W Mt Ave.

19 Filed 2 13 1946 (b) Huntington Willard Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12th 1946, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946 to Feb 12 1946 and that I last saw her alive on Feb 12 1946.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Arteriosclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. Estabrook M. D.
Address 1015 N. Calvert St Date signed Feb 12 1946

VS 150

G37369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37369 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dreer & Cedarwood
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Burke's
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 E. Biddle St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Beata Ward (Beata McDowell Ward)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frank A. Ward

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 16/1883

8. AGE: Years	Months	Days	If less than one day
63	0	25	hr. min.

9. Birthplace Balto. County (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Edw. J. McDowell

13. Birthplace Md

MOTHER 14. Maiden Name Beata Mayer

15. Birthplace Md

16 (a) Informant Miss Catharine B. Ward (Daughter)

(b) Address 208 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-46 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto City Md.

18 (a) Funeral director STEWART & HOOVEN COMPANY

(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

FEB 12 1946 (Date rec'd by Registrar) (b) Burlington Williamson (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1946 at 1.05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1946, to 2-10 1946, and that I last saw her alive on 2-10 1946

Immediate cause of death	Duration
Cardiac failure -	
Due to hypostatic c-v disease -	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George B. Callender M. D.

Address Hosp. Hosp. Reduced + Dee Date signed 2-11-46

93D

G37370 ✓ G37370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2543 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Thomas.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Frank Thomas.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4-1871.

8. AGE: Years 74 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and State)

10. Usual Occupation House Wife.

11. Industry or business At home.

FATHER — 12. Name Richard Thomas
13. Birthplace Dorchester Co. Md.

MOTHER — 14. Maiden Name Unknown.
15. Birthplace Germany.

16 (a) Informant Mrs. Frank J. Thomas.
(b) Address 2543 W. Fairmount Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Feb. 14-46. (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

FEB 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 - 1946. at 2.50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 31 to Feb 11 1946, and that I last saw [illegible] alive on Feb. 10 19 46

Immediate cause of death: Apoplexy

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Apoplexy 1 week; Hypertension 14 yrs.; Arteriosclerosis 6 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.

Address 505 N. Monroe St. Date signed Feb 13 46

G37371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49C

G37371 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 Greenmount Ave
(c) Hospital or institution: Southern Hospital + Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida O Amoss

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Edgar L Amoss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1863

8. AGE: Years	Months	Days	If less than one day
82	8	20	hr. min.

9. Birthplace Mary Land (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name John E Barnes
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Haberseth
15. Birthplace Md.

16 (a) Informant Mrs Maude Brown
(b) Address 1903 Pennsylvania Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)
(c) Cemetery or crematory Mt. View
Location Alpha, Howard Co. Md.

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

Filed FEB 13 1946 (b) Huntington W. Va. M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946 at 4 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 12 1946, and that I last saw h[illegible] alive on Feb 11 1946

Immediate cause of death	Duration
Coronary Thrombosis	?
Due to Coronary Occlusion	14 hrs ?
Due to	
Other Conditions — Cyst	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature C. W. Thompson M.D.
Address 2 West Read St Date signed 2/13/46

— X

G37372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G37372 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 N. Pearl St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 N. Pearl st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Felberta Godfrey.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eleanor.

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 5-15-1891

8. AGE: Years 54 | Months 8 4 | Days 27 | If less than one day hr. min.

9. Birthplace Portsmouth Va
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Daniel Godfrey

13. Birthplace Va

MOTHER 14. Maiden Name Kate ?

15. Birthplace Va

16 (a) Informant Eleanor Godfrey

(b) Address 911 N. Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946 at 1.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1946 to Feb 11 1946 and that I last saw h alive on Feb 11 1946

Immediate cause of death: Coronary Occlusion

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Hartzwell M. D.

Address 632 Franklin St Date signed Feb 12, 46

G37373
CWK-99674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G37373
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 7-
(e) Length of stay in Baltimore (yrs., mos., or days) 16- 4- 14-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Arlington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Winfield

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27-1929

8. AGE: Years	Months	Days	If less than one day
16	4	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Nathaniel Winfield
13. Birthplace Virginia

MOTHER
14. Maiden Name Grace Locke
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 Carrollton Ave

19 (a) Date received 2-13-1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946 at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1945, to Feb. 11 1946, and that I last saw h. alive on Feb. 11 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis, chronic, pneumo. thorax, on r/t.	
Due to	
Due to	
Other Conditions Ileo-cecal tuberculosis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. B. Gerrigon
Address Baltimore City Hosp. Date signed 2-11-46 M.D.

VS 150

G37374 BALTIMORE CITY HEALTH DEPARTMENT X V 637374

CERTIFICATE OF DEATH 107

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore — Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8197 Boundary Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Averitt (AVERITT) V

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6 - 1945

8. AGE: Years | Months: 6 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thos. F. Averitt
13. Birthplace Pa.

MOTHER
14. Maiden Name Anna Hunterbrink
15. Birthplace Balto.

16 (a) Informant Parents
(b) Address 8197 North Boundary Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave

19 (a) FEB 13 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1946 at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D. Medical Examiner.
Date signed 2-11-46

VS 151

X

G37375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G37375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmont
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. North Stuart ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ruby Hyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr. William Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1897

8. AGE: Years 48 | Months 9 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Hassell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mildred Slaughter
15. Birthplace North Carolina

16 (a) Informant Mr. William Hyman
(b) Address North Stuart Ave

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave & Back River Neck Rd

18 (a) Funeral director John F. Connelly
(b) Address 2 S Eastern Ave

19 (a) Date received FEB 13 1946 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1946 to Feb 12 1946, and that I last saw her alive on Feb 12 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Shock	
Due to Tumor of ovary (adenocarcinoma).	
Other Conditions Carcinomatosis	

(Include pregnancy within 3 months of death)

Date of operation 2-9-46

Major findings of operation: Large tumor of ovary (adenocarcinoma)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. DeWitt Peet M. D.

Address Church Home & Hospital Date signed 2-12-46

X

G37376-1 Perouty ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

G37376 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) V
(d) Street No. 914 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Perouty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-88

8. AGE: Years	Months	Days	If less than one day
43	6	16	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Adolph Perouty
13. Birthplace France

MOTHER 14. Maiden Name Caroline Zimmerman
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director John J. Connelly
(b) Address 416 Eastern Ave. Balto

19 (a) FEB 13 1946 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946 at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1946 to Feb 10 1946 and that I last saw h alive on Feb 10 1946.

Immediate cause of death	Duration
Circulatory Failure	1 hr
Due to Lobular Pneumonia	3 days
Due to Perforated Ulcer	5 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/6/46
Major findings of operation Perforated Peptic Ulcer
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Cannon III M. D.
Address Johns Hopkins Hospital Date signed 2/10/46

X

VS 150

G37377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33B

Registered No. G37377

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 S. Sharp St.
(c) Hospital or institution: no

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ... (b) County ...
(c) City or town Baltimore Md (If outside city or town limits write RURAL and give town)
(d) Street No. 1027 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ...

3 (a) FULL NAME Cambose Watkins

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ...

6 (c) If alive, give age — years

7. Birth date of deceased (month, day, year) Not Known

8. AGE: Years 76 yrs. | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Kent Island Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business ...

FATHER 12. Name not known
13. Birthplace not known

MOTHER 14. Maiden Name not known
15. Birthplace not known

16 (a) Informant Joseph Johnson
(b) Address 1028 S. Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 108 W Montgomery St

19 (a) FEB 13 1946 (b) [illegible] Baltimore, Md.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1946 to Feb 8 1946 and that I last saw h[illegible] alive on Feb 8 1946

	Duration
Immediate cause of death: Influenza	2 week
Due to: Old Age	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature [illegible] M. D.
Address 901 S. Sharp St Date signed 2/13/46

VS 150

G37378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

G37378 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Welcome Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Strickland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1903

8. AGE: Years 43 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Alexandria Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John ?
13. Birthplace Va

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Va

16 (a) Informant Henry Strickland
(b) Address 117 Welcome Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvin
Location Balt City

18 (a) Funeral director Isaiah L. Brown & Co
(b) Address 108 W. Montgomery St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 13 1946

VS 451

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1946, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subacute glomerular nephritis
Peritonitis

Due to

Other Conditions Anasarca

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skiarelis M.D. Medical Examiner.
Date signed 2-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37379

CWR-10150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G37379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2-
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F. Love

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Amelia Unlauft Love

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15-1864

8. AGE: Years	Months	Days	If less than one day
81	8	25	hr. min.

9. Birthplace Maryland (Cardover)
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Self

FATHER
12. Name Henry Love
13. Birthplace Maryland

MOTHER
14. Maiden Name ? Unknown
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL CEM.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 13 1946 (Date received by registrar) (b) Registrar

Huntington Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1946, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1946, to Feb. 12 1946 and that I last saw h. im alive on Feb. 12 1946

Immediate cause of death	Duration
Bronchopneumonia	7
Due to	
Due to	
Other Conditions Hypertrophied arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: none
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 2-12-46

G37580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 a

Registered No. G37580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Eaton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Feick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1857

8. AGE: Years 70 Months 2 Days 16 If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

NOTES — FATHER
12. Name Charles White
13. Birthplace Maryland

NOTES — MOTHER
14. Maiden Name Lawson ?
15. Birthplace Maryland

16 (a) Informant Eugenia Feick (Daughter)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or cremator Loudon Park
Location

18 (a) Funeral director Charles P. Powell
(b) Address 847 Edmondson Ave

19 (a) Filed [illegible] 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1946, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3, 1946 to Feb 10 1946 and that I last saw her alive on Feb 10, 1946

Immediate cause of death: Acute Coronary Thrombosis — Duration

Due to Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 32 Upper Mall Date signed 2-10-46

Waiting for Williams, M.D.

VS 150

G37381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53C

G37381 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 CLAESSEN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REUBEN ALPERSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 4 1913

8. AGE: Years 32 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation DRUGGIST

11. Industry or business

FATHER
12. Name JOSEPH
13. Birthplace RUSSIA

MOTHER
14. Maiden Name DORA
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-13-46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location GERMAN HILL RD

18 (a) Funeral director Jack Leuz Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) FEB 13 1946 (b) Huntington Williams, M.D.

VSH 50

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1946 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1946, to 2-12 1946, and that I last saw him alive on 2-12 1946

Immediate cause of death Cardiac insufficiency — Duration

Due to Rheumatic cardio-vasc. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley Roy Stanford M. D.
Address Sinai Hosp Date signed 2-13-46

X

G37382 BALTIMORE CITY HEALTH DEPARTMENT G37382

CERTIFICATE OF DEATH 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Dennlyn Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL or give town)
(d) Street No. 3225 Vickers Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Caplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Oscar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Max Goldman
13. Birthplace Russia

MOTHER 14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Oscar Caplan
(b) Address 3225 Vickers Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location East Balto St

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 13 1946

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1946 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1945 to Feby 12 1946, and that I last saw h... alive on Feby 11 1946.

	Duration
Immediate cause of death: Carcinomatosis: Lung metastases, peritoneal metast	5 mos
Due to: Carcinoma of sigmoid	
Due to: Jaccs to history	8 mos
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation No operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl. Date signed 2-12-46

X

G37383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37383 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai
(c) Hospital or institution: Monument St 3'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1121 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hillersohn, Louis A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race wh | 6 (a) Single, married, widowed, or divorced Div.

6 (b) Name of husband or wife Lizzie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Marcus Ostro
(b) Address 810 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-46 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzug Assn

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) FEB 13 1946 (Date rec'd by registrar) (b) Washington for Wilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12-1946 at 5:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12-1946, to 2-12-1946 and that I last saw h~~im~~ alive on 2-12-1946

Immediate cause of death	Duration
Myocardial Insuff- Cancer	
Due to Myocardial fibrosis, Coronary sclerosis	
Due to Hypertensive + Arteriosclerotic Heart Disease	
Other Conditions Gangrene left leg due to thrombosis femoral artery; Pulm. oedema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no abuse

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Lader M. D.
Address Sinai Hospital Date signed 2-12-46

VS 150

G37384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G37384 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3812 Barrington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Barrington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Gershenson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-5390

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Sophie Nee Gedrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1880

8. AGE: Years 65 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Furrier

FATHER
12. Name Philip Gershenson
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie Biller
15. Birthplace Russia

16 (a) Informant Benjamin Gershenson
(b) Address 2103 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b) Registrar

FEB 13 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946 at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1946 to 2-11 1946, and that I last saw h[illegible] alive on 2-11 1946.

Immediate cause of death	Duration
Coronary embolism	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Levy M.D.

Address 2301 Jordan Ave Date signed 2/11/46

X

G37385 BALTIMORE CITY HEALTH DEPARTMENT G37385

CERTIFICATE OF DEATH

93D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Eastern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROMAN GASIOROWSKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 12/15/88

8. AGE: Years	Months	Days	If less than one day
57	1	26	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Gasiorowski
13. Birthplace Poland

MOTHER
14. Maiden Name Katherine Kopcinska
15. Birthplace Poland

16 (a) Informant Mrs. Jessie Kujawa
(b) Address 1010 S. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Ave.

19 (a) FEB 3 1946 (Date received by registrar) (b) Huntington Willis Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1946, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1946, to Feb 11 1946, and that I last saw h[illegible] alive on Feb. 11 1946.

Immediate cause of death	Duration
Myocardial Insufficiency with Pulmonary Edema	1 day
Due to Chronic Myocarditis	4 yrs.
Due to Arteriosclerosis and Hypertension	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Gasiorowski M. D.
Address 1402 Eastern Ave Date signed 2-12-46

VS 150

G37386 ✓ G37386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 S. Ann St.
(If rural give location)
(e) Citizen of foreign country? Poland (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Kamasinski (Kamosa)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife MARY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 20, 1873

8. AGE: Years	Months	Days	If less than one day
73	—	21	hr. min.

9. Birthplace ~~Germany~~ Poland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Andrew Kamasinski
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kwiatkowski
15. Birthplace Germany

16 (a) Informant Mrs. Leo Kamosa
(b) Address 142 N. Potomac St.

17 (a) BURIAL (b) Date thereof 1/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL Road

18 (a) Funeral director M. J. Lodzinski & Son
(b) Address 1808 Eastern Ave.

19 (a) (b) Huntingdon Hill
(Date received by registrar) FEB 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1946, to Feb 11 1946 and that I last saw h.. alive on Feb 11 1946.

Immediate cause of death	Duration
Cardiac-resp failure	
Due to Cerebral Vascular accident	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Milton Latham M. D.
Address Mercy Hosp Date signed 2/11/46

G37387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37387

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bel Air Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. E. Main (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** VINCENT VALIANTI

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex M

5. Color or race White Italian

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Josephine Casteleannie

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 29, 1888 est.

8. AGE: Years 57 (est.) Months 8 Days 13 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state).

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Cesare Valiantis

13. Birthplace Italy

MOTHER 14. Maiden Name Anna Sabatina

15. Birthplace Italy

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16 - 1946 (month) (day) (year)

(c) Cemetery or crematory Westminster St. Johns

Location Westminster, Md.

18 (a) Funeral director H. Bankard & Son

(b) Address Westminster, Md.

19 (a) FEB 13 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/46 19 at 3:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1946 to 2/13 1946, and that I last saw him alive on 2/13 1946.

	Duration
Immediate cause of death CORONARY THROMBOSIS	10 DAYS
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.

Address LINDEN & MADISON STS. Date signed 2/13/46

X

CMK-90961 G37388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/38

G37388 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2- 7-
(e) Length of stay in Baltimore (yrs., mos., or days) 60- 7- 8-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William C. Crumbacker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2-1885

8. AGE: Years	Months	Days	If less than one day
60	7	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Crumbacker (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Null (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave + Laynade St

18 (a) Funeral director Harry H Wetzle
(b) Address 4101 Edmondson Ave

19 (a) FEB 13 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH February 10 1946, at 2:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1945, to Feb. 10 1946 and that I last saw h 1m alive on Feb. 10 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Saint

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B Feland M. D.
Address Balt. City Hosp. Date signed 2/12/46

Hart Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Emersonian Apts. Eutaw Place & Lake Drive.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Emersonian Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HORTENSE L. FEDERLEICHT.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David Federleicht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1862.

8. AGE: Years 82 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Simon Block,
13. Birthplace Alsace Lorraine.

MOTHER
14. Maiden Name Caroline Ephraim,
15. Birthplace Alsace Lorraine.

16 (a) Informant Mrs. L. Greif, (Daughter)
(b) Address Slade Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.13.46. (month) (day) (year)
(c) Cemetery or crematory: Baltimore Hebrew
Location Balto., Md.

18 (a) Funeral director: Harris Sonnenschein & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11th. 1946 at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1940 to Feby 11 1946, and that I last saw her alive on Feby 11 1946.

Immediate cause of death *	Duration
Carcinomatosis about	1 yr
Due to Carcinoma of breast (Operation)	1940
Due to * Pulmonary edema	2 days
Other Conditions Arteriosclerosis, heart disease, generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation June 1940
Major findings of operation: Carcinoma of right breast
of autopsy: Carcinomatosis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed

VS 150

G37390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57B

G37390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5507 South Bond Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry M. Cotton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jobe Cotton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 1, 1873

8. AGE: Years 72 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Merchant Tailor

11. Industry or business

FATHER
12. Name: Jacob B. Cotton
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rebecca ?
15. Birthplace: Russia

16 (a) Informant: Mr. Myron S. Cotton
(b) Address: 5507 South Bond Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: Balto. Md.

18 (a) Funeral director: Harris Sondheim & Son
(b) Address: 1902 Eutaw Place

19 (a) FEB 13 1946 (Date rec'd by registrar) (b) Registrar

Funeral for Wife

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1946, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1945, to Feb 12 1946, and that I last saw him alive on Feb 12 1946.

Immediate cause of death: Cachexia — Duration

Due to: Metastatic Leiomyosarcoma of Stomach

Due to: Carcinoma of Prostate

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: Feb 6

Major findings of operation: Carcinoma of prostate with metastases to bone & regional lymph nodes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. B. Birnbaum M.D.
Address: Sinai Hospital Date signed 2/12/46

X

G37391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 North Bentalou Street
(c) Hospital or institution: ********
(d) Length of stay in hospital or inst. (yrs., mos., or days) *******
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 North Bentalou Street
(If rural give location)
(e) Citizen of foreign country? ********** (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH R. HILL

3 (b) If veteran, name war ****
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife James H. Hill Sr.
6 (c) If alive, give age D, years

7. Birth date of deceased (mo., day, yr.) May 11, 1860

8. AGE: Years 85 | Months 9 | Days 1 | If less than one day ******** hr. min.

9. Birthplace Batimore Maryland
(Town, county, and state)
10. Usual Occupation Housewife at Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace England

MOTHER
14. Maiden Name ? Reisinger
15. Birthplace England

16 (a) Informant Mr. John A. Hill (son)
(b) Address 32 N. Bentalou Street

17 (a) Burial (b) Date thereof Feb. 14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetry
Location 3801 Frederick Ave. Balto.

18 (a) Funeral director C. B. Shubert Asst.
(b) Address 1300 Eutaw Place

19 (a) Date received by Local Registrar FEB 13 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 February 1946 at 3:A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1944 to 2/12 1946 and that I last saw h sr alive on 2/12 1946

Immediate cause of death Cerebral Hemorrhage — Duration (?)

Due to Arterio Sclerosis — (?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel E. Bogorad M.D.
Address 1905 W. Baltimore St. Date signed 2/ /46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G37392 Registered No. G37392

G37392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 Christian Street
(c) Hospital or Institution: **********
****
(d) Length of stay in hospital or inst. (yrs., mos., or days) **********
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Christian Street
(If rural give location)
(e) Citizen of foreign country? ******** (Yes or No)
If yes, name country ********

3 (a) FULL NAME CHARLES B. KLINE

3 (b) If veteran, name war: NO.
3 (c) Social Security Account No. 705-05-6224

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret M.
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 12 -1889

8. AGE: Years 56 | Months 7 | Days 28 | If less than one day: ********** hr. ..... min.

9. Birthplace: Elkton, Maryland (Town, county, and state)
10. Usual Occupation: Brakeman
11. Industry or business: Baltimore & Ohio R.R.

FATHER
12. Name: ? Kline
13. Birthplace: Elkton Maryland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Elkton, Maryland

16 (a) Informant: Frank D. Kline (son)
(b) Address: 2115 Christian Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13-46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.
Location Elkridge, Maryland, Md.

18 (a) Funeral director: J. B. Hilbert & Son
(b) Address 1300 EUTAW PLACE

19 (a) ..... (b) ..... Registrar
(Date rec'd by Local Reg.)
FEB 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1946 at 8:10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1945 to 2/10 1946
and that I last saw h 1m alive on 19

Immediate cause of death	Duration
Arterio sclerotic heart disease	1 yr.
Due to	
Due to	
Other Conditions Cerebral thrombosis aged (Cerebral)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: --No.---

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 WILKENS AVE. Date signed

Dr. Ben. Miller.

G37393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √93D

G37393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 N. Gay St
(c) Hospital or institution: 8th V

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 N Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Lee Hankey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or wife Mary Hankey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 26th 1885

8. AGE: Years	Months	Days	If less than one day
60 61	10	15	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Shoecutter

11. Industry or business American Brewery

FATHER
12. Name Clinton Hankey
13. Birthplace Md

MOTHER
14. Maiden Name Emma Muth
15. Birthplace Md

16 (a) Informant Mrs Mary Hankey
(b) Address 1626 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14th 1946 (month) (day) (year)

(c) Cemetery or crematory Balto
Location E North Ave Este

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N Patterson Park Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11th 1946, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1946, to Feb. 11, 1946, and that I last saw him alive on Feb. 11, 1946.

Immediate cause of death	Duration
Coronary occlusion	10 days
Due to	
Due to	
Other Conditions Chronic Myocardi tis	3 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert G Dingwall M. D.
Address 1613 E. North Av. Date signed 2-12-46

X

Dr Sylvest
280 Hartford Rd

G37394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4136 The Alameda
(c) Hospital or institution: 91

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 4136 The Alameda (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rose Moeslein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/9/1871

8. AGE: Years 74 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Joseph Roth
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kinnon
15. Birthplace York Pa.

16 (a) Informant John Moeslein
(b) Address 4136 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank A Seitz
(b) Address 814 W 36 St.

19 (a) (Date rec'd by registrar) (b) Registrar Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1946 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18/1937 to 2-12-1946, and that I last saw her alive on 2-11-1946

Immediate cause of death: Coronary occlusion — Duration 6 mos.
Due to arteriosclerosis — Duration Remarkable
Due to —
Other Conditions Arthritis deformans — Duration 15 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Sylvest M. D.
Address 802 Hartford Rd Date signed 2-12-46

G37395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1172

G37395 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F. Mullen

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-6297

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie R. Mullen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1887

8. AGE: Years	Months	Days	If less than one day
58	7	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Machanist
11. Industry or business Cole Muffin & Safety Vault

FATHER
12. Name Bernard I. Mullen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Reynolds
15. Birthplace Baltimore

16 (a) Informant Mrs. Annie Mullen
(b) Address 1012 Brentwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1946 to Feb 11 1946, and that I last saw him alive on Feb 11 1946

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Gastric ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1724 w Lombard St Date signed 2-12-46

PB Scagnetti 1712 W. Lombard St X

G37396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1659

Registered No. G37396

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 237 Oakley Village (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/46

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Charles C. Harrison
13. Birthplace Pa

MOTHER
14. Maiden Name Gladys Nixon
15. Birthplace Pa

16 (a) Informant Father
(b) Address 237 Oakley Village

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12th 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co. Md.

18 (a) Funeral director B. B. Hardy
(b) Address 1000 S. Pace St.

19 (a) FEB 13 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1946, at 3:25 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1946, to 2/12 1946 and that I last saw h.c.l. alive on 2/12 1946.

Immediate cause of death Bilateral area to prematurity

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. H. D. Elsässer M. D.
Address St. Agnes Hosp. Date signed 2/13/46

VS 150

G37397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37397 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Av.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 237 Oakley Village (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/46

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles E

13. Birthplace

MOTHER 14. Maiden Name Gladys Nixon

15. Birthplace Pa.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12th 1946 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem

Location A. A. Co. Md.

18 (a) Funeral director B. B. Hart

(b) Address 1000 S. Paca St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1946, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1946 to 2/12 1946 and that I last saw h[illegible] alive on 2/12 1946.

Immediate cause of death Atelectasis

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. N. O'Neill Jr

Address St. Agnes Hosp Date signed 2/13/46 M. D.

Huntington Williams, M.D.

G37398 G37398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1357 Ward St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) VI
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1357 Ward St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** Barbara Green

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1945

8. AGE: Years	Months	Days	If less than one day
	7	29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Greene
13. Birthplace N C

MOTHER 14. Maiden Name Evelyn Green
15. Birthplace Baltimore Md

16 (a) Informant Evelyn Green
(b) Address 1357 Ward St

17 (a) Burial (b) Date thereof Feb. 14 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) 2-13-1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946 at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1946 to 2-11 1946 and that I last saw h[illegible] alive on 2-11 1946

Immediate cause of death Bronchial Pneumonia — Duration .1 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 53 Y Dolphin St Date signed 2-11-46

G37399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No. G37399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Balto General Hosp Dom

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1730 Riverside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Bowen

3 (b) If veteran, name war Wonder Work
3 (c) Social Security Account No. 214-03-6423

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife Thelma LaVerne Bowen
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 - 1918

8. AGE: Years 27 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Cat Dresser
11. Industry or business Diamond Cut

FATHER 12. Name Nathaniel A Bowen
13. Birthplace Md

MOTHER 14. Maiden Name Lelia Stinnett
15. Birthplace Md

16 (a) Informant Mrs. J. A. Bowen
(b) Address 1730 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Cameron & Ave

18 (a) Funeral director J. D. Fokes, Agent
(b) Address 1314 E. Lexington St

FEB 13 1946 (Date received by registrar) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Feby 1946, at 4:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William A Helbrich M.D.
Medical Examiner.
Date signed 12 Feb'y '46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as the law requires. Any information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37400

485825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G37400

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 56
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Vincent Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Miles.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-92

8. AGE: Years 53 52 | Months | Days 10 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Home. wife

11. Industry or business

FATHER 12. Name Frank Peal

13. Birthplace 2,

MOTHER 14. Maiden Name Anna's Green

15. Birthplace 2,

16 (a) Informant Relative.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Md

18 (a) Funeral director Wm. H. Kelson

(b) Address 1303 Pressman

19 (a) FEB 13 1946 (Date filed by registrar) (b) Number Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1946, at 11.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25 1945 to Feb. 10 1946 and that I last saw h[illegible] alive on Feb. 10 1946

Immediate cause of death Myocardial failure — Duration

Due to Mitral stenosis and insufficiency

Due to Rheumatical heart disease

Other Conditions Pyelonephritis chronic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theresa D Stephens M. D.

Address Johns Hopkin Hospital Date signed 2-11-46

VS 150

1

G37401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37401 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Redwood & Bway
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town B
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Little Walsh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Duppins

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1878

8. AGE: Years 67 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Stevens Duppins
13. Birthplace md

MOTHER 14. Maiden Name —
15. Birthplace

16 (a) Informant Mary Duppins
(b) Address 1815 Little Walsh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. U. Nelson
(b) Address 1303 Presstman St

19 (a) FEB 13 1946 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1946 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1946 to 2-10 1946 and that I last saw h[illegible] alive on 2-10 1946.

Immediate cause of death	Duration
Acute pulmonary Edema	1 day
Due to Cardiac failure	10 days
Due to Hypertension Arteriosclerotic Cardiovascular Disease	7 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin A. Johnson M. D.
Address Nanticoke Hospital Date signed 2-10-46

D X

G37402

487575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G37402 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-23-90

8. AGE: Years	Months	Days	If less than one day
55	5	20	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation messenger

11. Industry or business

FATHER 12. Name Solomon Waters

13. Birthplace Md.

MOTHER 14. Maiden Name Ida White

15. Birthplace Md.

16 (a) Informant Relative

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Md

18 (a) Funeral director Geo. S. Kelson

(b) Address 1303 Pleasant St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946, at 12.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1946, to Feb 12 1946, and that I last saw Wms alive on Feb. 12 1946

Immediate cause of death: Primary Carcinoma of Lung — Duration ?

Due to

Due to

Other Conditions Metastases to Liver(b) + Spine — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Ord. adm.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Wilkins M. D.

Address Johns Hopkins Hospital Date signed 2-12-46

VS 150

G37403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G37403

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claiborne Harrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1901

8. AGE: Years	Months	Days	If less than one day
46	11	24	hr. min.

9. Birthplace Buckingham Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name ? Carroll
13. Birthplace Va.

MOTHER
14. Maiden Name Amanda Carroll
15. Birthplace Va.

16 (a) Informant Opa Christian
(b) Address 1929 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Wm. Robert A. Oliver, Jr.
(b) Address 1129 N. Caroline St.

19 (a) Filed [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1946, at 3:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945 to Feb. 10 1946 and that I last saw h[illegible] alive on Feb. 10, 1946

Immediate cause of death	Duration
Uremia	
Due to Gangrene [illegible]	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. V. Purcell M. D.
Address 422 E. Chase Date signed 2-12-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G37404 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 Cliftwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Cliftwood Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Katherine Budde

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife xGeorge Herman Budde
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John P. Kessler
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Emmerich
15. Birthplace Germany

16 (a) Informant Mrs. William D. Hobine
(b) Address 2024 Cliftwood Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-46 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore, Md.

18 (a) Funeral director E. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date received by registrar) (b) Harrington Williams, Registrar

FEB 13 1946

MEDICAL CERTIFICATION 5.40

20. DATE OF DEATH Feb. 10, 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2- 1946, to Feb-10 1946, and that I last saw her alive on Feb 9- 1946.

Immediate cause of death	Duration
Acute Dilatation of Heart.	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Gill Wall M. D.
Address 1631 E. North av Date signed Feb 11-46

G37405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37405 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 E. Baltimore
(c) Hospital or institution:
6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Krutzer

3 (b) If veteran, name war

3 (c) Social Security Account No. Veteran

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary Maurer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24-1883

8. AGE: Years 62 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Ind
(Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business Dry Goods

FATHER
12. Name
13. Birthplace Baltimore Ind

MOTHER
14. Maiden Name Mary Schmidt
15. Birthplace Baltimore

16 (a) Informant Ruth Krutzer
(b) Address 2900 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Frank V. Pipetone
(b) Address 2[illegible] E. Baltimore St

19 FEB 13 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11th 1946, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Feb 11 1946 and that I last saw him alive on Feb. 11 1946.

Immediate cause of death	Duration
Cerebral arteriosclerosis	?
Myocarditis	?
Due to Bronchopneumonia	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David F. Klemes M. D.

Address 2623 E. Monument Date signed 2/12/46

VS 150

X

G37406 Weigle G37406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83Q

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3828 W. Rawsale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3828 W. Rawsale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Raymond Weigle

3 (b) If veteran, name war: None.

3 (c) Social Security Account No. 212-07-0198

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ivan H. Weigle
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 27 1889

8. AGE: Years	Months	Days	If less than one day
56	8	14	hr. min.

9. Birthplace Prospect Pa.
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business American Stove Co.

FATHER
12. Name William Weigle
13. Birthplace Pa.

MOTHER
14. Maiden Name Katherine Akin
15. Birthplace Pa.

16 (a) Informant Ivan H. Weigle
(b) Address 2828 W. Rawsale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Howard W. Hurlbrink
(b) Address 306 Main St. Irvington

19 (a) FEB 13 1946 (Date filed with registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27-45 to 2-11-46, and that I last saw h alive 2-11-46

Immediate cause of death: Cerebral Hemm. — Duration: 1 day

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry S. Gentil M. D.
Address 2703 E. Monument Date signed 2-12-46

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

Registered No. G37407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Appeal
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Drusilla White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18 [illegible]

8. AGE: Years 60 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Calvert, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Augustus Carpenter.
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Gross.
15. Birthplace Md.

16 (a) Informant Helen Hunter.
(b) Address 234 N. Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Lusby, Md.

18 (a) Funeral director P. E. Sewell
(b) Address Prince Frederick, Md.

19 (a) (Signature of registrar) (b) Registrar

FEB 13 1946 Huntington Millstone, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 12 1946 and that I last saw h[illegible] alive on Feb 12 1946.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to

Due to Neoplasm of Endometrium [illegible] over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 2-7-1946
Major findings of operation: Surrounding Carcinoma
of autopsy: Sarc; Hydronephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Hosp. Date signed 2/13/46

X

G37408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1150

Registered No. G37408

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2245 Sidney Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2245 Sidney Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter Howard Cain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1945

8. AGE: Years	Months	Days	If less than one day
	5	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Cain
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Marie Berger
15. Birthplace Balto. Md.

16 (a) Informant Mrs. George Cain
(b) Address 2270 Sidney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Ritchie Highway

18 (a) Funeral director Krapf Funeral Home
(b) Address 1216 N. Charles St.

19 (a) (Date received by registrar) (b) Lovington Williams, M.D. Registrar

FEB 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946 to Feb 10 1946 and that I last saw h[illegible] alive on 19

Immediate cause of death: Streptococcus Septicemia — Duration: 2 days

Due to: Streptococcus Infection

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul [illegible] M.D.
Address [illegible] Date signed 2/13/46

over

G37409

CWE-99162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G37409 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Elliott Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antoinette Rudnicki

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John (D)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 13-1885
8. AGE: Years 60 Months 7 Days 28 If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Liganowski
13. Birthplace Poland

MOTHER
14. Maiden Name Rose Slocka
15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 FEB 12 1946 (b) Huntington Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946 at 4:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1946 to Feb. 11 1946, and that I last saw her alive on Feb. 11 1946.

Immediate cause of death Cardiac decompensation — Duration ?
Due to Rheumatic heart disease aortic & mitral stenosis — ?
Due to
Other conditions Pneumonia & Pulmonary infarction — ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy As above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. M. Pfeltz M. D.
Address Balto City Hosp Date signed 2-11-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G37410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G37410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Laterbe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martin Thompson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lyda Sparks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1883

8. AGE: Years 62 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business

FATHER
12. Name Martin Thompson Sr
13. Birthplace Va.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant Virginia Berry
(b) Address 1202 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. County

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Caroline St

19 (a) (Date of death or burial) (b) Huntington Williams, M.D.

FEB 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1946, to Feb 12 1946, and that I last saw h[illegible] alive on Feb 12 1946.

Immediate cause of death	Duration
Bilateral Lobar Pneumonia	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Osmund Wiener M. D.
Address Univ. Hosp Date signed 2/14/46

G37411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

300

G37411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Eastern Ave (Bengies)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 7 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Bengies Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Jerome Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Sarah Johnson
(b) Address Middle River

17 (a) Burial (b) Date thereof Feb. 14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto Md

18 (a) Funeral director Mrs. Robert S. Ellwood
(b) Address 1129 E. Caroline St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams

FEB 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946 at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945, to Feb 11 1946, and that I last saw him alive on Feb 11 1946.

Immediate cause of death	Duration
Cardiac failure	
& Uremia	
Due to Arteriosclerotic C-Vas. Disease	
Due to	
Other Conditions Uremia Gangrene Left foot CVS Lobar Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Osmund Wiener M. D.
Address Univ. Hosp. Date signed 2/13/46

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. G37412

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSP. 13 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 568 W. UNIVERSITY PARKWAY
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR ELMER ELSWORTH BRAMBLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife (D) Margaret C. Bramble
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 4, 1880

8. AGE: Years	Months	Days	If less than one day
65	7	9	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation BANKING
11. Industry or business

FATHER
12. Name BARZILLIK BRAMBLE (D)
13. Birthplace MARYLAND

MOTHER
14. Maiden Name CLARA LANGRILL
15. Birthplace MARYLAND

16 (a) Informant Mr. M. Roland Bramble, Brother
(b) Address 400 Bretton Place

17 (a) Burial (b) Date thereof 2/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. Pikesville, Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 13 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 13 1946 at 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 1 1946 to FEB 13 1946 and that I last saw HIM alive on FEB 13 1946

Immediate cause of death	Duration
UREMIA	
RESULTING FROM POST OP ANURIA	
Due to PARALYTIC ILEUS	
FOLLOWING RESECTION	
Due to OF SIGMOID COLON FOR CARCINOMA	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-1-46
Major findings of operation: CARCINOMA OF SIGMOID.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M. D.
Address Union Memorial Hosp. Date signed 2/13/46

VS 150

X

G37413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G37413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Boone St. #18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Usher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation H Wife

11. Industry or business

FATHER 12. Name Daniel Dolan

13. Birthplace Ireland

MOTHER 14. Maiden Name Ann Tanahan

15. Birthplace Ireland

16 (a) Informant Francis P. Usher

(b) Address 2100 Boone St

17 (a) Cathedral (Burial, cremation, or removal) (b) Date thereof 2-14-1946 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director Mary M. Wedefeld

(b) Address 921 E. 22nd St

19 (a) FEB 13 1946 (Date received by Local Reg.) (b) Huntington Hollins, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21- 1946, to 2-11 1946 and that I last saw her alive on 2-11 1946.

Immediate cause of death	Duration
Uremia	
Due to Pneumococcus meningitis	
Due to arteriosclerotic C V D	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.

Address St. Joseph's Hosp Date signed 2-11-46

X

G37414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G37414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 Bryant Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Bryant Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Edythe Cohen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter Cohen
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 1 1887

8. AGE: Years	Months	Days	If less than one day
58	7	11	hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Kafka
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Jenker
15. Birthplace Austria

16 (a) Informant Walter E. Cohen
(b) Address 2104 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 1946 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew Cemetery
Location Belair Rd

18 (a) Funeral director J. Ubersax & Co
(b) Address 2432 Reisterstown Rd

19 (a) Date received by registrar FEB 13 1946 Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1942, to 2-12-1946. and that I last saw he alive on 2-12-1946.

Immediate cause of death	Duration
Chronic Nephritis	
14 yrs Pertinent	1 yr
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature I. E. Michelson M. D.
Address 2730 Eutaw Pl Date signed 2/13/46

R. A. X Michelson

G37415 BALTIMORE CITY HEALTH DEPARTMENT G37415

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S Curley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella White

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm W. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25-86

8. AGE: Years 59 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? Appleby

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Unknown

15. Birthplace Baltimore Md

16 (a) Informant Wm W. White

(b) Address 114 S Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] (Day) (Month) (Year) 2/14/46

(c) Cemetery or crematory [illegible]

Location [illegible]

18 (a) Funeral director John C Moran

(b) Address 3800 E Baltimore St

19 (a) FEB 13 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to 2/11 1946 and that I last saw h alive on 2/11 1946.

Immediate cause of death	Duration
Arteriosclerosis Cerebral	1 Yr
Due to Coronary Thrombosis	
Due to Hypostasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geraldine J. Judd M.D.

Address 3312 E. Baltimore St Date signed 2/14/46

VS 150

G37416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

G37416 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2617 E. Fairmount Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie T. Grasmick

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John

6 (c) If alive, age: 29 years

7. Birth date of deceased (mo., day, yr.): Jan 9 1887

8. AGE: Years 67 ~~65~~ | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER 12. Name: John F. Fitzgerald

13. Birthplace: Balto

MOTHER 14. Maiden Name: Annie Seese

15. Birthplace: Balto.

16 (a) Informant: George W. Grasmick

(b) Address: 2617 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)

(c) Cemetery or crematory: Loudon Parkwood

Location: Taylor Ave

18 (a) Funeral director: John A. Horan

(b) Address: 3602 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1919 to Feb 12 1946, and that I last saw h.e alive on Feb 12 1946

Immediate cause of death: Cerebral Hemorrhage

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm. Kent Insley M. D.

Address: 2516 E Balto Date signed: 2-15-46

VS 150

(over)

X

G37417 BALTIMORE CITY HEALTH DEPARTMENT G37417
CERTIFICATE OF DEATH 830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mo 17dy
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County –
(c) City or town Baltimore - 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Springfield Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Conrad Vollmer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bertha M. Vollmer
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) 9 March 1876
8. AGE: Years 69 | Months 11 | Days 3 | If less than one day ... hr. ... min.
9. Birthplace Dingelbe, Germany (Town, county, and state)
10. Usual Occupation Manufacturer
11. Industry or business Baker

FATHER
12. Name Jacob Vollmer
13. Birthplace Germany

MOTHER
14. Maiden Name Domig ?
15. Birthplace Germany

16 (a) Informant Dr. Frederick C. Vollmer
(b) Address 6100 York Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15-46 (month) (day) (year)
(c) Cemetery or crematory Mem. Bath.
Location Old Frederick Rd.
18 (a) Funeral director John. J. Horan
(b) Address 4801 Fremont Av
19 (a) Feb 13 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1946 at 12 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1941 to Feb 12 1946, and that I last saw him alive on Feb 12 1946.

Immediate cause of death	Duration
Cerebral thrombosis, ab	4yrs 3mos
Due to Arteriosclerosis, cerebral	
Due to	
Other Conditions Hemiplegia, left	4yrs 3mos

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick C. Vollmer M. D.
Address 6100 York Rd. Date signed Feb 12, 46

G37418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37418
Registered No.

48796. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 861 S. Wallace St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Joseph Cummings.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-90

8. AGE: Years	Months	Days	If less than one day
55	4	18	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Bartender.
11. Industry or business

FATHER
12. Name Joseph Cummings
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary J Christian
15. Birthplace N.Y.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)
(c) Cemetery or crematory
Location Oregon New York

18 (a) Funeral director John. G. Hodson
(b) Address 3000 E Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1946 at 6. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1946 to Feb. 13 1946, and that I last saw him alive on Feb. 13 1946.

Immediate cause of death	Duration
PNEUMONIA, RIGHT UPPER LOBE	10 DAYS
Due to PNEUMOCOCCUS TYPE 14	
Due to	
Other Conditions UREMIA, CAUSE UNDETER. (Include pregnancy within 3 months of death)	2 DAYS

Date of operation
Major findings of operations
of autopsy SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. P. Clasper M. D.
Address Johns Hopkins Date signed Feb 13, 1946

X

G37419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

806 Registered No.

G37419

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Rosedale
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7919 E 35th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth C Turner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Orville C Turner
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Oct. 5 - 1919

8. AGE: Years	Months	Days	If less than one day
26	4	8	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation At Home.
11. Industry or business

FATHER
12. Name Herman Zimmerman
13. Birthplace Md

MOTHER
14. Maiden Name V
15. Birthplace V

16 (a) Informant Mrs. Orville C. Turner
(b) Address 7919 E. 35th St.

17 (a) Burial (b) Date thereof 2-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland.
Location Baltimore

18 (a) Funeral director Leonard J. Buck
(b) Address 530 S Holford Rd

FEB 13 1946 (b)
(Date received by local registrar) Huntington Woods Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946, at 3:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1946 to 2/13 1946 and that I last saw her alive on 2/13 1946

Immediate cause of death: Pulmonary - Cardiac failure — Duration

Due to Decreased Intracranial Pressure

Due to Brain tumor

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 2/12/46
Major findings of operation: Brain Tumor
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Antony Jaworski M.D.
Address St. Joseph Hospt. Date signed 2/13/46

over

KELVIN JAWORSKI

1 Copy 637420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

637420 ✓

Registered No. 1316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 E. Chase St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Thomas Hendershott

3 (b) If veteran, name war: Yes
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Pamella
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1871
8. AGE: Years 74 | Months | Days | If less than one day: hr. ..... min.
9. Birthplace Giles Co., Tenn (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Geo. Hendershott
13. Birthplace Giles Co. Tenn.

MOTHER
14. Maiden Name Mina Hopkins
15. Birthplace Giles Co. Tenn

16 (a) Informant Darnell Hendershott
(b) Address 1402 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14-1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Arbutus Md

18 (a) Funeral director Robert J. Williams
(b) Address 1515 Madderry St

19 (a) Feb 1946 (b) Date rec'd by registrar Thos. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1946, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Feb 9 1946, and that I last saw h[illegible] alive on Feb 9 1946.

Immediate cause of death: Chronic Nephritis (uremia)
Due to .....
Due to .....
Other Conditions Enlarged Prostate
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: none

Duration: Probably Complications

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....
23. Signature Ralph J. Young
Address 1 Troy St Baltimore Md Date signed 2/13/46

X

G37121

487870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 a

G37121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington D.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 74 Fayc St. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nell Lowman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Charles Lowman (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 4-5-96

8. AGE: Years	Months	Days	If less than one day
49 50	10	8	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER 12. Name Wayman Williams
FATHER 13. Birthplace Pa.
MOTHER 14. Maiden Name ? ?
MOTHER 15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Washington, D.C.

18 (a) Funeral director Francis J Collins
(b) Address 3821-14th St. N.W. Washington, D.C.

FEB 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1946, at 4. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1946 to Feb 13 1946 and that I last saw her alive on Feb. 13 1946.

Immediate cause of death Uremia — Duration ?
Due to Carcinoma of cervix with metastases
Due to
Other Conditions
(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt Lowman M. D.
Address Hopkins Hosp. Date signed 2-13-46

VS 150

G37422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37422

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frost Alrich

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mona

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 1879

8. AGE: Years 68 | Months 5 6 | Days 3 26 | If less than one day hr. min.

9. Birthplace St Louis Mo (Town, county, and state)

10. Usual Occupation Museum

11. Industry or business Bath Symphony Orchestra

FATHER
12. Name Carl F Rochlich
13. Birthplace Germany

MOTHER
14. Maiden Name Louis Acker
15. Birthplace Germany

16 (a) Informant Hugo M Friedrich
(b) Address St Louis Mo

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Old St Morens
Location St Louis Mo

18 (a) Funeral director Wilson Funk Inc
(b) Address 1217 E Pont St

19 (a) (Date received by Registrar) (b) Huntington Williams Md Registrar

FEB 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1946, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1945 to 2-12 1946 and that I last saw him alive on 2-10 1946

Immediate cause of death: Coronary Occlusion — Duration: Four hrs.

Due to Arteriosclerotic Heart Disease

Due to Pt had an Anterior Myocardial Infarct On 12-19-45

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Katherine H Pinkerton M. D.
Address 11 E Chase St Date signed 2-12-46

G37423

JL - 95303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G37423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Victor Kapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Viola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1896

8. AGE: Years	Months	Days	If less than one day
49	7	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward V. Kapp
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Gault
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Fulton Lock Inc
(b) Address 1217 E. Cold St

19 (a) (Date rec'd by registrar) (b) Huntington Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1946, at 6.55P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1945 to Feb. 11 1946 and that I last saw h in alive on Feb. 11 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert F. Copeland Jr M.D.
Address Balt. City Hosp Date signed 2/12/46

VS 150

G37424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G37424 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown
(If outside city limits, write RURAL and give town)
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown Olger Dalseth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 1921

8. AGE: Years: 25 | Months | Days | If less than one day: hr. min.

9. Birthplace: Aalesund, Norway
(Town, county, and state)

10. Usual Occupation: Seaman

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Norway

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Norway

16 (a) Informant: Norwegian Consul
(b) Address: Md Trust Building

17 (a) Cremation (b) Date thereof 2/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore

18 (a) Funeral director: Tilton Funeral Home
(b) Address: 1217 E Cont St

19 (a) FEB 14 1946 (b) Huntington W. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12th 1946, at 2a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry; find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 12 1946 1:05 P.M.
(b) Where did injury occur? Front: Harbor foot of Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Drowning

23. Signature: Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2-12-46

VS 151

X

G37425 G37425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hoy Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Chinese	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) abt-1898-

8. AGE: Years	Months	Days	If less than one day
abt-48	?	?	hr. min.

9. Birthplace China
(Town) (county) and state)

10. Usual Occupation Cook
11. Industry or business Restaurant

FATHER
12. Name ?
13. Birthplace China

MOTHER
14. Maiden Name ?
15. Birthplace China

16 (a) Informant Mr. James Wen
(b) Address 408 Park Ave. - City

17 (a) Burial (b) Date thereof 2-15-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(W. F. Mowen Asst.) 100 W. North Avenue
(b) Address

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 14 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1946 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tetanus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarlis M.D.
Medical Examiner.
Date signed 2-13-46.

X

...item of information should be carefully supplied. The ...correct age is especially important. Physicians: please write the c...

G37426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G37426

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2438 S. Paca St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2438 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarice Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1945

8. AGE: Years | Months: 8 9 | Days: 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name George Williams
13. Birthplace North Carolina

MOTHER
14. Maiden Name Alice Toney
15. Birthplace South Carolina

16 (a) Informant George Williams
(b) Address 2438 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) FEB 14 1946 (Date received by registrar) Washington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1946 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1946 to 2/12 1946 and that I last saw him alive on 19

Immediate cause of death: Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 2/13/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 6 ✓

G37427 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert - Saratoga
(c) Hospital or institution:
Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Clotine Ann Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21, 1945

8. AGE: Years	Months	Days	If less than one day
1	13	22	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Carter
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mildred Solomon
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 2005 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15/46 (month) (day) (year)

(c) Cemetery or crematory Oakland
Location Fairfax Ave.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date received by registrar) (b) Interment for Williams M.D. Registrar

FEB 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946, at 5 18 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1946, to 2-12 1946 and that I last saw her alive on 2-12 1946.

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary edema & hemorrhage — 36 hr.

Due to Meningococcemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul R. Meyer M. D.

Address Mercy Date signed 2-12-46

X

G37428

BALTIMORE CITY HEALTH DEPARTMENT ✓ 94a

CERTIFICATE OF DEATH

Registered No. G37428

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Aisquith Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE MITTENDORFF

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Annie E. Mittendorff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 6, 1868

8. AGE: Years 77 | Months 8 | Days 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: B.O.R.R. Relief Dept
11. Industry or business: Ret. 12 yrs. Veteran

FATHER
12. Name: Charles Mittendorff
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Hohman
15. Birthplace: Germany

16 (a) Informant: Mrs. Annie Mittendorff
(b) Address: 714 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-15-45 (month) (day) (year)
(c) Cemetery or crematory: Louden Park Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 14 1945 (Date Rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH February 13 1945 at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1945 to 2/12 1945 and that I last saw him alive on 2/12 1945

Immediate cause of death: Acute Cardiac failure — Duration:
Due to: Ch. myocardial weakness.
Due to: Ch. coronary arteriosclerosis.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Argyle St Date signed 2/13/45

X

G37429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G37429

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3220 Tyndale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Tyndale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carlo Pietro Miglionetti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Secondina Miglionetti

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) November 28, 1866

8. AGE: Years 79 | Months 2 | Days 15 | If less than one day: hr. 14 min.

9. Birthplace: Italy (town, county, and state)

10. Usual Occupation: Retired Merchant

11. Industry or business: Self

FATHER
12. Name: Giacomo Miglionetti
13. Birthplace: Italy

MOTHER
14. Maiden Name: Rosa Bertone
15. Birthplace: Italy

16 (a) Informant: Mr. Louis Miglionetti
(b) Address: 3220 Tyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Taylor ave

18 (a) Funeral director: Henry N. Bright Jr.
(b) Address: 4914 Belair Road

19 (a) Date received: FEB 14 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1946, at 10.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1946 to Feb. 12 1946 and that I last saw him alive on Feb. 10, 1946

Immediate cause of death: Carcinoma - Intestines — Duration: 11/2 hrs.
Due to: ✓
Due to: ✓
Other Conditions: ✓

(Include pregnancy within 3 months of death)
Date of operation: about Oct. 1945
Major findings of operation: Carcinoma - mid-intestines
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Eugene L. Cervantes M. D.
Address: 514 Druid Park Lane Date signed 2/13/46

VS 150

X

G37430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 a

G37430 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2849 W. North Ave
(c) Hospital or institution: P.O.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2849 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Mayforth.

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Roselle E. Mayforth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1895

8. AGE: Years: 50 | Months: 5 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Haworth, N. J.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Wm. V. Mayforth
13. Birthplace: Haworth, N. J.

MOTHER
14. Maiden Name: Amelia Sherer
15. Birthplace: Switzerland

16 (a) Informant: Mrs. Roselle E. Mayforth
(b) Address: 2849 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (Date received) FEB 14 1946 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Tickner M.D.
Medical Examiner.
Date signed 2/15/46

VS 151

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939

G37431 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4217 Chatham Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Chatham Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY GUTTENBERG.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1861

8. AGE: Years 84 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ? Guttenberg.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. M. Dannenberg,
(b) Address 4217 Chatham Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.14.46. (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Bal to. Md.

18 (a) Funeral dir. Harris Levenson & Son
(b) Address 1902 Eutaw Place.

19 (a) (b) Huntington Williamsville, Md.

FEB 14 1946

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Feb. 12, 1946 at 7.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/23 1939 to 2/12 1946 and that I last saw h[illegible] alive on 2/12 1946

Immediate cause of death cardiac failure — Duration 25 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Wilson M. D.
Address 5721 Pk. Heights Ave. Date signed

X

G37432

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 1946

Registered No. G37432

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. CALVERT ST.
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ day

2. USUAL RESIDENCE OF DECEASED:
(a) State WEST VA. (b) County
(c) City or town GORMANIA
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLYN VIRGINIA HODGES

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG - 31 - 1944

8. AGE: Years	Months	Days	If less than one day
1	5	14	hr. min.

9. Birthplace BAKER, WEST VIRGINIA (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business

FATHER
12. Name JAMES E. HODGES
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name RUTH MORGAN
15. Birthplace VIRGINIA

16 (a) Informant JAMES E. HODGES (HOSPITAL RECORDS)
(b) Address GORMANIA, WEST VA.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory ROANOKE
Location ROANOKE VA.
18 (a) Funeral director Wilson Carter
(b) Address 1217 Kanawha
19 (a) FEB 14 1946 (Date rec'd by registrar) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 14 1946 at 5:00 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1946 to 2-14 1946 and that I last saw her alive on 2-14 1946

	Duration
Immediate cause of death CARDIAC FAILURE	1 DAY
Due to PROBABLE MEDIASTINITIS WITH PNEUMOTHORAX (PARTIAL)	1½ days
Due to OPEN SAFETY PIN LODGED IN LOWER ESOPHAGUS WITH PROBABLE PERFORATION	2½ days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph E. Read M. D.
Address Mercy Hospital Date signed 2-14-46

VS 150

G37433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 S. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Fulton

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 212-20-9422

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Nora Fulton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1881

8. AGE: Years 64 | Months 9 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name William Fulton
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Gronell
15. Birthplace Md.

16 (a) Informant George F. Fulton
(b) Address 313 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Holbrook & Gilmor St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

FEB 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1946 to Feb 12 1946, and that I last saw him alive on Feb 11 1946.

Immediate cause of death: Chronic Nephrosclerosis
Due to: Myocardial degenerations
Due to:
Other Conditions: Malnutrition

Duration: 2 mos.

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature John B. Holbrook Jr. M.D.
Address 1222 Druid Park Blvd Date signed Feb 13 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G37434

G37434

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 Cumberland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Cumberland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Bluma Epstein

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1897

8. AGE: Years	Months	Days	If less than one day
48	10	23	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Abraham Lebowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Faga ?
15. Birthplace Russia

16. (a) Informant Benjamin Epstein
(b) Address 625 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 15, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
(Signature and title) Registrar

FEB 14 1946 Washington Hilleman, M.D.

VS 150

MEDICAL CERTIFICATION

3.30

20. DATE OF DEATH February 13, 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1946 to Feb 13 1946 and that I last saw her alive on Feb 13 1946

Immediate cause of death Cerebral Hemorrhage — Duration 4 hours
Due to Hypertensive Cardio Vascular disease — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Where at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Levy, M. D.
Address 1844 W. North Ave Date signed 2/14/46

X

G37435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37435 Registered No. 1250

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 571 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Bertie Watkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/30/25

8. AGE: Years	Months	Days	If less than one day
20	10	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Godfrey Martin
13. Birthplace Md

MOTHER
14. Maiden Name Elyna Watkins
15. Birthplace Md

16 (a) Informant Oscar Carroll
(b) Address 571 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1383 Pressman St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

FEB 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946, to Feb 12 1946, and that I last saw h.r alive on Feb 12 1946.

Immediate cause of death	Duration
Acute yellow atrophy of Liver	1 week
Due to Anemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Osmund A. Swanson M. D.
Address Univ. Hosp. Date signed 2/13/46

X

637436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

637436 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1061 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Geneva Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr. 22, 1896

8. AGE: Years 49 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace: N. C.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Dwight Brown
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Caroline Whitley
15. Birthplace: N. C.

16 (a) Informant: Geneva Brown
(b) Address: 1061 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: MD

18 (a) Funeral director: Geo. H. Kelson
(b) Address: 1303 Prestman St

19 (a) (Date rec'd by registrar) FEB 4 1946 (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1946, at 11:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Bacterial Endocarditis

Vegetations Aortic + Mitral Valvulitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 2-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37437

487924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-8D

G37437

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County
(c) City or town Kingsport (If outside city or town limits, write RURAL and give town)
(d) Street No. 1256 Catawba St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Colman Parham.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha Stone Parham.
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 6-10-14

8. AGE: Years	Months	Days	If less than one day
31	8	3	hr. min.

9. Birthplace Long Hill, Tenn. (Town, county, and state)
10. Usual Occupation Industrial Relations
11. Industry or business

FATHER
12. Name Thomas A. Parham
13. Birthplace Tenn.

MOTHER
14. Maiden Name Margaret Colman
15. Birthplace Tenn.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory City Cemetery
Location Kingsport, Tenn.

18 (a) Funeral director Perkins & Wakefield Funeral Home
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 14 1946

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1946, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1946, to Feb. 13 1946, and that I last saw him alive on Feb. 13 1946.

Immediate cause of death	Duration
Cardiac Failure	6 wks
Anasarca, Azotemia	
Due to Rheumatic Heart Disease – Pericarditis	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Doctham M.D.
Address Johns Hopkins Hospital Date signed 2/15/46

G37438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Colvert
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 Ellerslie Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nannie L Dunbar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Wm. T.E. Husband

6 (b) Name of husband or wife Wm. T.E. Husband
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/2/65

8. AGE: Years	Months	Days	If less than one day
80	8	30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert V Logan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anne C. Clotworthy
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Lillian Dunbar
(b) Address 3815 Ellerslie Ave, Baltimore #18

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) (Registrar)

FEB 14 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1946, to 2/13 1946, and that I last saw her alive on 2/13 1946.

Immediate cause of death	Duration
Embolism Failure.	
Due to Fracture of Major Operation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Acute Gangrenous Cholecystitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins Jr. M.D.
Address Union Memorial Date signed 2/13

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G37439

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Harcourt Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Adelaide Hlavin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Andrew J. Hlavin
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 6, 1898

8. AGE: Years	Months	Days	If less than one day
47	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Corsetiere
11. Industry or business

FATHER
12. Name Edward Lange
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna M. Reise
15. Birthplace Balto. Md.

16 (a) Informant Miss Helen Lange
(b) Address 4203 Harcourt Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Sons Co.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11/1946, at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2/1946, to 2/11/1946, and that I last saw her alive on 2/11/1946.

Immediate cause of death: Toxemia — Duration: 9 days

Due to: Peritonitis, pleurisy, subdiaphragmatic abscess — 2 weeks

Due to: Ruptured Appendix — 2 weeks

Other Conditions: Atelectasis of L. lung

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ruptured Appendix

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Chesin
Address Sinai Hospital Date signed 2/11/46 M. D.

VS 150 FEB 14 1946 Harrington Williams, M.D. X

G37440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G37440

TN. 83251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-5-22
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roista Vojichich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26th ? 1881

8. AGE: Years ? 64 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Yugoslavia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Vojichich
13. Birthplace Yugoslavia

MOTHER
14. Maiden Name Josey ?
15. Birthplace Yugoslavia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Carpenter Pt. Rd.

18 (a) Funeral director Patsy Mono
(b) Address 1136 Lexington Williams, M.D.

19 (a) FEB 14 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb 7th 1946, at 2.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15-45 to Feb. 7th 46
and that I last saw h. in alive on Feb 7th 46

Immediate cause of death	Duration P
Chronic Myelogenous Leukemia	
Due to	
Due to	
Other Conditions ASHD Diabetes mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marguerite Davis M. D.
Address B.C.H. Date signed 2-13-46

VS 150

X

637441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

637441 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Harlem ave
(c) Hospital or institution:

16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Harlem ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Verna B. Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1899

8. AGE: Years	Months	Days	If less than one day
46	11	10	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Unknown
13. Birthplace Penna

MOTHER
14. Maiden Name Unknown
15. Birthplace Penna

16 (a) Informant Mr. Joseph E. Garner
(b) Address 1925 Harlem Ave

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 2801 Frederick Ave

18 (a) Funeral director John J. Conroy & Son
(b) Address 901-03 Hollins St

19 (a) Huntington Williams
(Filed by registrar) FEB 14 1946 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1946, at 1:42 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis with cavity formation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-14-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G37442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No. 2834 N Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Patrick Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1898

8. AGE: Years	Months	Days	If less than one day
47	1 SAIT	22	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business War Shipping Dept.

FATHER
12. Name James Phillips
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie E. Cairns
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Phillips, sister
(b) Address 2834 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16, 1946 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Kiedfeld
(b) Address 917 Fremont Ave

19 (a) FEB 14 1946 (b) Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Feby 1946 at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelpius M.D.
Medical Examiner.
Date signed 14 Feby 46

Hunting to William

G37443 G37443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson + Arlington
(c) Hospital or institution: West Balt. Gen. Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d
(e) Length of stay in Baltimore (yrs., mos., or days) 12d.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Fulton Ave.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL MEEKER - #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 28 1945

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Frank Joseph Geja
13. Birthplace Balt., Md.

MOTHER
14. Maiden Name Enid Meeker
15. Birthplace Balt., Md.

16 (a) Informant Mother
(b) Address 13 S. Fulton Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Dashiell
Location Hospital

18 (a) Funeral director
(b) Address

19 (a) DEC 11 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1945 at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1945 to 12/10 1945. and that I last saw h[illegible] alive on 12/10 1945

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Prematurity.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Ehrenfeld M. D.
Address West Balt. Gen. Hosp. Signed 2/5/46

VS 150

G37444 G37444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 W. Royal Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McFadden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/29/46

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward McFadden

13. Birthplace U. S.

MOTHER 14. Maiden Name Riley Mason

15. Birthplace Selbysportsville, Va

16 (a) Informant Mother

(b) Address 1337 W. Royal Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School FEB 12 1946

18 (a) Funeral director Commissioner of Health

(b) Address

FEB 14 1946 Hunter Scott Williams M.D.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946 at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1946 to Jan 29 1946 and that I last saw h.... alive on Jan 29 1946

Immediate cause of death Pneumothorax — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Pneumothorax

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. H. Forrestal M.D.

Address 25 Eutaw Pl. Date signed 2/6/46

3298 Lowenstein X

G37445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G37445
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hayes

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male
5. Color or race Black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1946

8. AGE: Years 0 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name William Hayes
13. Birthplace Mecklenburg, Virginia

MOTHER
14. Maiden Name Beatrice Byrnes
15. Birthplace Raleigh, N.C.

16 (a) Informant father
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 14 1946 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1946 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1946 to 2-7 1946 and that I last saw him alive on 2-7 1946

Immediate cause of death Pneumonia — Duration

Due to atelectasis

Due to Prematurity (7 mo.)

Other Conditions Cong. Syphilis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed Leonner M.D.
Address Univ. Hosp. Date signed 2-7-46 M. D.

13297

X

G37446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓161C

G37446 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) life 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Moore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1946

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Moore
13. Birthplace Washington, N.C.

MOTHER
14. Maiden Name Roena Clement
15. Birthplace Washington, N.C.

16 (a). Informant Mrs. Roena Moore
(b) Address 828 W. Saratoga St. Baltimore Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 13 1946
18 (a) Funeral director Commissioner of Health
(b) Address
FEB 14 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1946 at 4:39 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1946, to 2-8 1946, and that I last saw him alive on 2-8 1946.
Immediate cause of death Anuria

Duration

Due to Hyperglycemia severe
Due to Maternal diabetes severe
Other Conditions Erythroblastosis fetalis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Almac Brown-Kelly M.D.
Address Univ. Hosp. Date signed Feb 10

3296 X

G37447

CWK-99059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√83a

G37447 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7732 Fairgreen Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Willard Ernest Carney

3 (b) If veteran, name war

3 (c) Social Security Account No. 210-01-0771

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 22-1904

8. AGE: Years	Months	Days	If less than one day
41	2	22	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Francis Carney
13. Birthplace Pa.

MOTHER
14. Maiden Name Dalia ?
15. Birthplace Pa.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Removal (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Amath Cem.
Location New Florence Pa.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 FEB 15 1946 (b) [illegible] Registrar
(Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1946, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1946, to Feb. 14 1946, and that I last saw h im alive on Feb. 14 1946

Immediate cause of death Intracranial hemorrhage — Duration 8 days.
Due to Coryza ? Pneumonia ? ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. M. Phillippi M. D.
Address Balt City Hosp Date signed 2-14-46

VS 150

G37448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G37448 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynew & Dukeland
(c) Hospital or institution Mt Dalto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Edgewater Apt. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Lohr

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 Feb. 46

8. AGE: Years | Months | Days 13 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Charles McGeen Lohr
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Evelyn Rogers
15. Birthplace Georgia

16 (a) Informant Charles M. Lohr
(b) Address Edgewater Apt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)
(c) Cemetery or crematory
Location Brooklyn Georgia

18 (a) Funeral director Henry Semple
(b) Address 6167 Colton Ave Rd.

FEB 15 1946 (Date rec'd by registrar) (b) Clinton Hillman

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 February 1946 at 1:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Feb 1946 to 14 Feb 1946 and that I last saw h/m alive on 14 Feb 1946

Immediate cause of death Bronchopneumonia
Unknown

Duration

Due to
Due to Diarrhoea.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Hall Jr M. D.
Address 5166 H Date signed 2/14/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37449 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G37449

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Prince George
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Souder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/12/46

8. AGE: Years | Months | Days: 1 | If less than one day: 29 hr. 50 min.

9. Birthplace Univ. Hosp. Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Souder
13. Birthplace MD

MOTHER 14. Maiden Name Margaret Buckley
15. Birthplace West Virginia

16 (a) Informant William Souder
(b) Address Laurel Md

17 (a) Burial (b) Date thereof 2/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Laurel Md.

18 (a) Funeral director Lloyd Lauer
(b) Address Laurel Md

19 (a) (Date received by Registrar) (b) Registrar

FEB 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 14 1946 at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 12 1946 to FEB 14 1946, and that I last saw M alive on FEB 12 1946

Immediate cause of death: RESPIRATORY FAILURE — Duration

Due to: FETAL ATELECTASIS

Due to: PREMATURITY

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Jamison M. D.

Address Univ. Hosp Date signed 2-15-46

X

637450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 637450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 Stamford Rd
(c) Hospital or institution:

28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Stamford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Curt H. Hirsch

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife Helene M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1879

8. AGE: Years	Months	Days	If less than one day
66	7	22	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Ernest J. Hirsch
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Schlegel
15. Birthplace Germany

16 (a) Informant Mrs. Helene Hirsch
(b) Address 634 N. Stamford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson ave

19 (a) 2-5-1946 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946, at 10 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1945 to Feb 12 1946.
and that I last saw him alive on Feb 12 1946.

Immediate cause of death Coronary Occlusion — Duration 10 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Van Schuyver M. D.
Address 818 Edmondson Ave Date signed 2/14/46

G37451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G37451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 N. Fairvale
(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Fairvale Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	col	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1882

8. AGE: Years	Months	Days	If less than one day
63 64	10		hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Thomas
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Priscilla
15. Birthplace Calvert Co. Md.

16 (a) Informant Eliz. Abrams
(b) Address 525 N Fairvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) FEB 15 1946 (Date rec'd by registrar) (b) Huntingtown Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946 to Feb 12 1946 and that I last saw h. alive on Feb 12 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	?
Due to Decrepitation	
Other Conditions Old age	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Wheatley M. D.
Address 1220 Druid Hill Ave Date signed 2/15/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G37452

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5807 CLOVER RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5807 CLOVER RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY AARON PASS

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ANNA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name SAMUEL PASS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name SARAH
15. Birthplace RUSSIA

16 (a) Informant DR. I. EARL PASS
(b) Address 4001 WILKENS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHILA RD. + HAMILTON AVE

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (Signature) (b) Baltimore, Md.

FEB 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1946 at 7.23 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1946, to 2-14 1946 and that I last saw him alive on 2-12 1946

Immediate cause of death Carcinomatosis of stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of stomach & metastases

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul E. Carlenius M. D.
Address 2217 South Pk Date signed 2-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G37453 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olivia Kuszmaul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife 2

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16th 1876

8. AGE: Years 69 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Martin Russell
13. Birthplace Md.

MOTHER
14. Maiden Name Susan (Unknown)
15. Birthplace "

16 (a) Informant Mrs. Lillian Safranek
(b) Address 734 E. 36½ St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to 2/13 1946, and that I last saw h[illegible] alive on 2/13 1946

Immediate cause of death Coronary Thrombosis — Duration 6 Weeks

Due to Hypertension

Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Sudler
Address 3323 E. Balto St Date signed 2/14/46 M. D.

VS 150

FEB 15 1946

Hunt for Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

File No. 37454 30686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. G37454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 345 Elrino St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ely Cox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26th 1869

8. AGE: Years 76 | Months 1 | Days 18 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Cox
13. Birthplace Maryland

MOTHER
14. Maiden Name Ford
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) FEB 15 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14th 1946 at 5.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20th 1946 to Feb. 14 1946 and that I last saw him alive on Feb. 14 1946

Immediate cause of death Multiple pulmonic embolism - Duration 4 wks
Brain, viscera and
Due to bowels strangulated
Due to Auricular fibrillation
Other Conditions Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. M. Phillippi
Address Balt City Hosp. Date signed 2-14-46

VS 150

G37455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G37455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 E. Preston st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George M. Hardy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22nd 1865

8. AGE: Years	Months	Days	If less than one day
80	2	21	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Samuel Norris
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Frances Sanders
15. Birthplace Harford Co. Md.

16 (a) Informant C. Raymond Hardy Jr.
(b) Address 4604 Benton Heights Ave

17 (a) Burial (b) Date thereof 2/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Abingdon
Location Harford Co Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13th 1946, at 8 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1943 to February 1946, and that I last saw her alive on 9th Feb. 1946.

Immediate cause of death	Duration
Endocarditis	
Due to	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael Reto M.D.
Address 3005 St Paul St. Date signed Feb 14 1946

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37456 ✓ G37456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital ~~or institution~~: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Winton st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ralph. C. Martinez

3 (b) If veteran, name war

3. (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17 1946

8. AGE: Years	Months	Days	If less than one day
		27	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ralph C. Martinez
13. Birthplace Ponce Rico

MOTHER
14. Maiden Name Dorothy Cenarik
15. Birthplace Balto. Md.

16 (a) Informant Dorothy Martinez
(b) Address 1319 Winton St.

17 (a) Burial (b) Date thereof 2/15/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address St. Paul St.

FEB 15 1946

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/46 19 , at 4.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1946, to 2/13 1946, and that I last saw h~~im~~ alive on 2/13 1946

Immediate cause of death	Duration
Pneumonia	
Metastases from testis	
sepsis, pyelonephritis	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: pyelonephritis, metastases from testis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Rodo M. D.
Address Sinai Hosp Date signed 2/14/46

VS 150

G37457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G37457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1738 E Baltimore St
(b) Street address (Home)
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Krupinske

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1878

8. AGE: Years	Months	Days	If less than one day
67	6	29	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Alexander Krupinsky
(b) Address 1822 N. Bethel St.

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 (a) (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1946, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Feb 13 1946, and that I last saw h alive on 2-13 1946.

Immediate cause of death Myocarditis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Snyder M. D.
Address 163X E. Baltimore Date signed 2/14/46

VS 150

2

637458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ 637458 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 S. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Pauline Krzniewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Walter Krzniewski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Steve
13. Birthplace

MOTHER
14. Maiden Name Katarzyna Zaczek
15. Birthplace

16 (a) Informant Helen Majka
(b) Address 1106 S Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director John F. Duda
(b) Address 2529 Hudson St

19 (a) (Date rec'd by Registrar) (b) Registrar

FEB 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1946 to 2/13 1946, and that I last saw h[illegible] alive on 2/13 1946

Immediate cause of death: Diabetic Coma
Due to: diabetic acidosis
Due to: Diabetes mellitus
Other Conditions: Coronary occlusion
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd Jr.
Address St Josephs Hosp Date signed 2/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

637459

637459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W Caroline St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Kentucky Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Carrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Earl R. Carrick
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) April 11 1894

8. AGE: Years	Months	Days	If less than one day
51	10	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Samuel J Grice
13. Birthplace Md

MOTHER
14. Maiden Name Sarah E Preston
15. Birthplace Md

16 (a) Informant Earl R Carrick
(b) Address 3414 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md & Co Md

18 (a) Funeral director Wentz Funeral Home
(b) Address 2008 Bleecker St

(Date rec'd by registrar) FEB 15 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1946, to 2/13 1946, and that I last saw her alive on 2/13 1946.

Immediate cause of death: Meningococcus Meningitis — Duration

Due to

Due to

Other Conditions Bronchopneumonia bilateral

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Gordon L. Jones M. D.
Address Franklin Sq. Hosp. Date signed 2/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PARAGRAPH RESERVED FOR BINDING

G37460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 G37460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 N Patterson Park
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N Patterson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa C Kristian

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M F	W.	Married

6 (b) Name of husband or wife John C Kristian
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Aug 23 1884

8. AGE: Years	Months	Days	If less than one day
61	5	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Edw Stansbury
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Meyer
15. Birthplace Md

16 (a) Informant John C Kristian
(b) Address 703 N Patterson Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 18 (month) (day) (year)
(c) Cemetery or crematory Pg Memorial Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 13 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1946 to Feb 13 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Hypostatic Cong Pneumonia	
Due to Influenza	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Hunkowski 24 M. D.
Address 2079 Eastern Ave Date signed

VS 180

FEB 15 1946 Huntington Will Registrar

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G37461 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 E. Eagw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ma. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 E. Eagw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Lockmiller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13-1878

8. AGE: Years	Months	Days	If less than one day
67 66	6	-	hr. 1 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Md Penitentiary

FATHER
12. Name Henry Lockmiller
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Neidhardt
15. Birthplace Germany

16 (a) Informant Herman C. Lockmiller
(b) Address 2402 E Eager St

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ellrid Funeral Home
(b) Address 2008 Aliceanna St

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1946 at 11 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Fibrosis ~~Coronary Thrombosis~~ Arteriosclerosis

Due to OSTEOMYELITIS, RT. JAW

LOBULAR PNEUMONIA

Other Conditions CARONIC PERICARDITIS (ora)
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chas Lee Gratiot M.D.
Medical Examiner.
Date signed 2-13-46

Huntington Milwaukee

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G37462 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 ea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Goetze

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 Th 1946 at 1:45 P. M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Dora Goetze

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 - 1868

8. AGE: Years	Months	Days	If less than one day
77	6	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business

FATHER
12. Name August Goetze
13. Birthplace Germany

MOTHER
14. Maiden Name Ecean Leidmeyer
15. Birthplace Germany

16 (a) Informant R Melvin Goetze
(b) Address 1711 Lakeside

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Immanuel Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (b)
(Date rec'd by registrar) Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Massive cerebral hemorrhage

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 2-14-46.

VS 151

Thursday Feb

G37463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G37463 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Coufal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Coufal
6 (a) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-65

8. AGE: Years 80 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Moravia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Coufal
13. Birthplace Czech.

MOTHER
14. Maiden Name Frances Fajman
15. Birthplace Czech

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pt. Lookout Cemetery
Location

18 (a) Funeral director Ellicott Funeral Home
(b) Address 200 E. Pleasant St.

19 (a) FEB 13 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1946 at 9:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1946 to 2-12 1946 and that I last saw h[illegible] alive on 2-12 1946

Immediate cause of death dehydration and starvation — Duration

Due to Ca of esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-29-46

Major findings of operation: gastrostomy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Stueller M.D.
Address The Johns Hopkins Hosp. Date signed 2-12-46

Keating for Williams, M.D. Registrar

VS 150

G37464

CWB-99197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G37464

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

11-4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 Dolphin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60 ?			hr. min.

9. Birthplace Unknown Baltimore-Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore-Md

18 (a) Funeral director Mrs. Francis J. Heuisler
(b) Address 574 W. Biddle St.

19 (a) (Date rec'd by Registrar) Huntington Williams (Registrar)

FEB 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1946 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1946, to Feb. 12 1946, and that I last saw him alive on Feb. 12 1946

	Duration
Immediate cause of death: Uremia	? days
Due to: Acute urinary retention	3 days
Due to: Prostatic hypertrophy	yrs ?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hosp. Date signed 2-14-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 637465

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Port Deposit
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1845

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Henry Morris
13. Birthplace England

MOTHER
14. Maiden Name Catherine Hayes
15. Birthplace New York

16 (a) Informant Jenkins Memorial Hosp.
(b) Address 1019 Caton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)

(c) Cemetery or crematory
Location Wilmington Del.

18 (a) Funeral director Martin Bayley & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

FEB 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/46 19 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to 2/14 1946, and that I last saw him alive on 2/14 1946.

Immediate cause of death	Duration
Heart failure	
Due to Arterio Sclerosis, Cardio Vasc. Disease	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cleff Catlett, Jr. M.D.
Address St Agnes Hosp. Date signed 2/14/46

X

G37466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37466
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 9 minutes
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) 12 5 minutes

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 E. Lafayette Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Gorsuch

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/46

8. AGE: Years | Months | Days | If less than one day: 1 hr. 45 min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward C. Gorsuch
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Siebert
15. Birthplace Baltimore Md.

16 (a) Informant Edward C. Gorsuch -Father
(b) Address 1410 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

FEB 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1946, at 4 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Cardio-Respiratory Failure — Duration:
Due to Anoxia
Due to Premature (5½ mos. gestation)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. K. Brendle M.D.
Address Mercy Hosp. Date signed 2/14/46

637467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

637467 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Greensfelder.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Martin Greensfelder
(b) Address 2013 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkoske
(b) Address 2007 Eastern Ave E.

19 (a) (Date rec'd by local registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Feb 14 1946 and that I last saw him alive on Feb 14 1946

Immediate cause of death Coronary Thrombosis — Duration 2/13/46

Due to

Due to Chr Myocarditis — 7/1/45

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R Bauer M. D.
Address 2012 Eastern Ave Date signed 2/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

637468 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 4
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Finetta Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1881

8. AGE: Years 64 65 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Amelia Va. (Town, county, and state)

10. Usual Occupation Midwife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Mildred Long

(b) Address 1224 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem.

Location

18 (a) Funeral director Mrs. Zorah Bayamore

(b) Address 1129 N Caroline St.

19 (a) (Date rec'd by registrar) (b) Registrar

Feb 15 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 29 1946 to Feb 11 1946 and that I last saw h.e.r. alive on Feb 11 1946.

Immediate cause of death: Congesting Heart Failure — Duration 3 weeks

Due to: Arterial Hypertension

Due to:

Other Conditions Arteriosclerosis & Hypertension

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McDonald M.D.

Address 844 N Carey Date signed 2/13/46

G37469 G37469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 E. Joppa Rd. - 4th Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/11/46

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David Jones

13. Birthplace

MOTHER 14. Maiden Name Mary Drinks

15. Birthplace Washington, D. C.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-46 (month) (day) (year)

(c) Cemetery or crematory St. Peters

Location Baltimore

18 (a) Funeral director George A. Loxley

(b) Address Fulton Ave + Gay St.

19 (a) (Entered by) (b) Registrar

FEB 16 1946

Huntington Williams, M.D.

VS-450

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946 at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1946 to 2/13 1946, and that I last saw him alive on 2/11 1946

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Tetanus Neonatorum	
Due to Patent Ductus Arteriosus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Patent Ductus Arteriosus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. E. Brendle M. D.

Address Mercy Hosp. Date signed 2/14/46

X

G37470

BALTIMORE CITY HEALTH DEPARTMENT

TN. 99201 CERTIFICATE OF DEATH 1937 Registered No. G37470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Edmonds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18th 1893

8. AGE: Years	Months	Days	If less than one day
52	5	26	hr. min.

9. Birthplace S. C (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16. (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1002 Brantley ave

19 (a) FEB 5 1946 (b) Huntington Mill Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 14th 1946 19 at 4.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11th 46 to Feb 14 46, and that I last saw h or alive on Feb. 14 19 46

Immediate cause of death Cardiac Decompensation

Due to Hypertensive Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. M. Phillipi M. D.
Address Date signed 2-14-46

D. M. Phillipi X

VS 150

G37471 ✓ BALTIMORE CITY HEALTH DEPARTMENT × ✓ G37471

TN. 99148 CERTIFICATE OF DEATH 160 Q Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bluefield W. Va.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9th 1946

8. AGE: Years	Months	Days	If less than one day
			hr. five min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace W. Va.

MOTHER
14. Maiden Name Eula
15. Birthplace Bluefield W. Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (records 3 PM

17 (a) Cremation (b) Date thereof Feb. 13-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) [illegible] crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) FEB 15 1946 Registrar Williams, M.D.
(Registrar's signature)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 9th 1946 19 at 7.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9th 19 46 to Feb 9th 19 46 and that I last saw h er alive on Feb 9th 19 46

Immediate cause of death Prematurity
Subarachnoid hemorrhage

Duration
4 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Same
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E Brightwell M. D.
Address Balt. City Hosp Date signed 2-13-46

VS 150

G37472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 10

Registered No. G37472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REASON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 Pitcher St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Pitcher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lethia Jackson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Widowed

6 (b) Name of husband or wife Abraham Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Lewis Conquest
13. Birthplace Md

MOTHER
14. Maiden Name Emma Miles
15. Birthplace Md

16 (a) Informant Cora Haines
(b) Address 602 Pitcher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 / 15 / 46 (month) (day) (year)
(c) Cemetery or crematory National Cem
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1309 Presstman St

19 FEB 15 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946, at 12. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945, to Feb. 12 1946, and that I last saw h[illegible] alive on 2-12 1945.

Immediate cause of death	Duration
Cardiac	
Due to Vascular	
Due to Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Butler M.D.
Address 2033 Orleans Date signed 2/17/46

VS 190

X

G37473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37473 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Barclay st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Bennett pl
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Burnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Burnes

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1888

8. AGE: Years 58 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Major Burnes
13. Birthplace Md

MOTHER 14. Maiden Name Louisa Briggs
15. Birthplace Md

16 (a) Informant John Burnes
(b) Address 3218 Barclay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 | 17 | 46 (month) (day) (year)

(c) Cemetery or crematory St Mary's Co. Md.
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Preastman st

19 (a) 2-15-1946 (Date rec'd by registrar) (b) Huntington Wills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1946 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1946 to Feb 13 1946 and that I last saw h[illegible] alive on Feb 13 1946.

Immediate cause of death Cardiac Vascular Insufficiency — Duration 1½ yrs

Due to

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts

Address 5154 Wingate Date signed 2/14/46 D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 ✓ Registered No. G37474

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2409 Stockton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Carter Colbert

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F.
5. Color or race C.
6 (a) Single, married, widowed, or divorced. W.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 Months Days If less than one day hr. min. 66

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name Annable
15. Birthplace

16 (a) Informant Herman Wilson
(b) Address 1625 McKean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Maryland

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 15 1946 (Date rec'd by registrar) (b) Huntington Phillips Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1946 at 11:a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1946 to Feb 13 1946 and that I last saw her alive on Feb 13 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1902 Penna Ave Date signed 2-14-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G37475 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 Carlton St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Carlton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hathe Winston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1898

8. AGE: Years 47 | Months 8 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Lucinda Mitchell
15. Birthplace Md.

16 (a) Informant Alfred Mitchell
(b) Address 1024 Carlton St.

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pressman St

19 (a) FEB 15 1946 (b) [illegible] Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1946, to Feb 13 1946, and that I last saw her alive on Feb 12 1946.

Immediate cause of death	Duration
Cardio Vascular Disease	6 mo's
Due to Broken Compression	2 mo's
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Penna Ave Date signed 2/14/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G37476 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Bensel

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-05-4191

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 6, 1901
8. AGE: Years 44 | Months 4 | Days 7 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Clerk
11. Industry or business Lord Baltimore Press

FATHER
12. Name Henry R. Bensel
13. Birthplace Md

MOTHER
14. Maiden Name Ida V. Behler
15. Birthplace Pa.

16 (a) Informant Mrs. Minnie E. Bensman
(b) Address 1712 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location 3310 Gaylor Ave

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 2296 Eager St

19 (a) (Date rec'd by registrar) FEB 18 1946 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1946, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1946 to 2/13 1946, and that I last saw him alive on 2/12 1946

Immediate cause of death: Acute Coronary Infarction — Duration
Due to: Chronic Hypertension
Due to: Chronic Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. H. Hamilton M. D.
Address 733 Argyle Ave Date signed 2/14/46

VS 150

G37477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G37477

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Collett st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eli Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Eliza —
15. Birthplace Va

16 (a) Informant Rev. Andrew Jackson
(b) Address 1355 N. Gilmor st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location: A. A. Co. Md.

18 (a) Funeral director Chas. A. Alexander
(b) Address 927 N. mount st

19 (a) FEB 15 1946 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis, intestinal tuberculosis, tuberculous pericarditis.

Other Conditions Emaciation.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed 2-12-46

SKITARELIC

637478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 637478

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 W Watt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara A Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/45

8. AGE: Years | Months 1 mo | Days 27 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Robt L Green

13. Birthplace S.C

MOTHER 14. Maiden Name Virginia Parey

15. Birthplace N.C.

16 (a) Informant Virginia Green

(b) Address 136 W West Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A A Co Md

18 (a) Funeral director Isaiah L Brown Son

(b) Address 10 E W Montgomery Street

19 (a) (b)

Date rec'd by registrar FEB 17 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Feb 46, at 11:50 M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William S Keyser M.D. Medical Examiner

Date signed 15 Feb 46

X

G37479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G37479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Russell St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Russell
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Bryant
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Wm a. Bryant
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/15/1905
8. AGE: Years 40 | Months 10 | Days 29 | If less than one day hr. min.
9. Birthplace Farmville N.C (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Holmes
13. Birthplace Farmville N.C

MOTHER
14. Maiden Name Flora Holmes
15. Birthplace N C

16 (a) Informant Willie Bryant
(b) Address 914 Russell St
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/15/46 (month) (day) (year)
(c) Cemetery or crematory Wilson
Location North Carolina
18 (a) Funeral director Josiah L Brown & Son
(b) Address 1020 Montgomery St
19 (a) (Date rec'd by registrar) (b) Registrar

FEB 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1946 at 8 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1946 to 2/13 1946 and that I last saw h[illegible] alive on 2/14/46.

Immediate cause of death	Duration
Due to Rt Lobar	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Faulcon M. D.
Address 1131 Druid Hill Ave Date signed 2/14/46

X

G37480 ✓ G37480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Dickeysville -7, - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5010 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moss

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-46

8. AGE: Years	Months	Days	If less than one day
			1 hr. 33 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Williamson Wade Moss
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Virginia Barton Peery
15. Birthplace Elkridge Md.

16 (a) Informant Williamson W. Moss
(b) Address 5010 Forest Park Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15 1946 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Wash. Blvd.
18 (a) Funeral director Frederick A. Cobb
(b) Address 1700 W Lombard St
19 (c) 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-46 19 at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11:57 A.M. 2/13 1946, to 1:30 A.M. 2/14 1946, and that I last saw him alive on 2/14 19 46

Immediate cause of death	Duration
Congenital Atelectasis	1½ hrs.
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature F. T. Mitchell Jr. M. D.
Address Bon Secours Hosp. Date signed 2/19/46

VS 8

G37481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37481

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N Chester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town write RURAL and give town)
(d) Street No. 104 N Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Esther Molly Applestein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years 93 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Cubin
13. Birthplace Russia

MOTHER
14. Maiden Name Olda
15. Birthplace Russia

16 (a) Informant Mrs Sophie Funkelstein
(b) Address 104 N Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-46 (month) (day) (year)
(c) Cemetery or crematory
Location Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 1[illegible]9 E Preston St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-14-1946 at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-12 1945 to Feb-14 1946 and that I last saw her alive on Feb-14-1946

	Duration
Immediate cause of death: senile cardiac vascular	
Due to: Selerosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Herman Seidel
Address 2404 Eutaw Place Date signed 2/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 637182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kans. (b) County
(c) City or town Independence
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 - 4. 8th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mickey Allen McKibben

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 - 14 - 43.

8. AGE: Years	Months	Days	If less than one day
2	5	1	hr. min.

9. Birthplace Oklahoma
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Mc Kibben
13. Birthplace Iowa.

MOTHER
14. Maiden Name Opal Callahan
15. Birthplace Oklahoma.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) 2/15/46 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Independence
Location

18 (a) Funeral director
(b) Address

19 (a) FEB 15 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2. 15 1946 at 7 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2. 10 1946 to 2. 15 1946, and that I last saw h[illegible] alive on 2. 15 1946.

Immediate cause of death CARDIAC FAILURE — Duration 15 HRS

Due to CONG. HEART DISEASE

Due to

Other Conditions EXTROPHIAN BLADDER

(Include pregnancy within 3 months of death)

Date of operation FEB 14 1946

Major findings of operation: TETRALOGY OF FALLOT

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Young M. D.
Address Johns Hopkins Hosp Date signed 2-15-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37483 ✓ Registered No. 1242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth ~~Kenealy~~ Kenealy Dempsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1897

8. AGE: Years	Months	Days	If less than one day
48	1	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ~~John~~ William Kenealy
13. Birthplace ~~Balto, Md.~~ N.Y.

MOTHER
14. Maiden Name ~~Mary Louise~~ Delia Kearns
15. Birthplace Balto, Md.

16 (a) Informant Mrs. M. Kenealy
(b) Address 805 E. Chase St

17 (a) Burial (b) Date thereof Feb 18, 1946 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Gramercy Mansion Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1946 to Feb 14 1946, and that I last saw h[er] alive on 2/14 1946.

Immediate cause of death	Duration
Cardiac decompensation	
Due to	
Due to Cirrhosis of liver (?) ascites	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Milton Lentheeum M. D.
Address Mercy Hosp Date signed 2/16/46

VS-150

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37484 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Baltic Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Darling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 - 46

8. AGE: Years | Months | Days: 10 | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Darling
13. Birthplace California

MOTHER
14. Maiden Name Ann Darling
15. Birthplace W. Virginia

16 (a) Informant Mrs Lyons
(b) Address 601 Baltic Ave (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Gor Fulton Highway

18 (a) Funeral director Mutton Stribling
(b) Address 3934 S. Hanover St

FEB 15 1946
Date rec'd by registrar (p) Hilda Whitaker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1946, at 440 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1946 to 2/15 1946, and that I last saw h. alive on 2/15 1946.

Immediate cause of death	Duration
Cardio Resp failure	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Painter M.D.
Address St Agnes Hosp Date signed 2/15/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G37485 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 E. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia A. Shelton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Courtlus Shelton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 5 1885

8. AGE: Years 61 Months 0 Days 28 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Henry Arnold
13. Birthplace

MOTHER
14. Maiden Name Anna E. Schmidt
15. Birthplace Baltimore Md.

16 (a) Informant Elmer M. Shelton
(b) Address 136 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanagan
(b) Address 1426 Light St.

19 (a) FEB 15 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 13th 1946 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Feb 13 1946. and that I last saw h[illegible] alive on Feb 13 1946

Immediate cause of death	Duration
Due to Cystitis	4 days
Due to Carcinoma of Liver & Rectum	Indefinite
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1644 Harlem Date signed 2/14/46

VS 150

G37486

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TH. 79655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G37486

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 11-22
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12th 1885

8. AGE: Years 60 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hawkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Queen
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc. Johns Hopkins Medical School FEB 15 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 15 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5th 1946 19 at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5th 19 46 to Feb. 5th 19 46 and that I last saw h im alive on Feb. 5th 19 46

Immediate cause of death Bronchopneumonia — Duration 2 days.

Due to Aspiration of foreign body.

Due to

Other Conditions A.S.H.D.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Feb 5th at P M
(c) Where did injury occur? 815 W. Lombard (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Choked while eating Frankfurter

23. Signature Margaret Davis M.D.
Address R. C.H. 125 Date signed 2-14-46

VS 150

3303 Signed: Addie Lee Gaston M.D.

G37487 ✓ G37487

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 min
(e) Length of stay in Baltimore (yrs., mos., or days) 35 min

2. USUAL RESIDENCE OF DECEASED: NEW BIRTH
(a) State (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Lansing Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WARD, BABY BOY

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/13/46

8. AGE: Years	Months	Days	If less than one day
			0 hr. 35 min.

9. Birthplace CHURCH HOME & HOSPITAL
(Town, county, and state)
10. Usual Occupation NEW BORN
11. Industry or business —

FATHER
12. Name WARD, GARLAND
13. Birthplace CICERO, INDIANA

MOTHER
14. Maiden Name WATSON, MILDRED
15. Birthplace BALTIMORE, MARYLAND

16 (a) Informant MRS C. WARD
(b) Address 1605 LANSING AVE, BALTO.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Johns Hopkins Medical School FEB 15 1946
18 (a) Funeral director Commissioner of Health
(b) Address
FEB 15 1946 Huntington Williams M.D. Registrar
(Date Rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1946, to 2/13 1946, and that I last saw h[illegible] alive on 2/13 1946.

	Duration
Immediate cause of death RESPIRATORY FAILURE DUE TO MULTIPLE CONGENITAL ANAMALIES	
Due to a- ABSENCE RT. LUNG & IMPERFORATE ANUS	
Due to a- SPINA BIFIDA AT MENINGOCELE	
Other Conditions b- CONG. POLYCYSTIC KIDNEYS	

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation:
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Potter M.D.
Address Church Home Hospital Date signed 2/14/46 M. D.

VS 1to

3301

X

G37488 ✓ G37488

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

TH. 99055 **CERTIFICATE OF DEATH** 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 54
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jerry Brown ✓

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1895

8. AGE: Years 51 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Unable to obtain any information
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 15 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 15 1946 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Feb. 5th 1946 19 at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5th 19 46 to Feb 5th 19 46 and that I last saw h im alive on Feb 5th 19 46

Immediate cause of death (Duration)
Pneumococcus Pneumonia — Days
Bacteriuria
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address B.C.H. Date signed 2-14-46

VS 150 3302 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[redacted] G37489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37489 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Freeden Ave
(c) Hospital or institution: Md. Steil. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Freemount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Wellman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation At Home.
11. Industry or business

FATHER
12. Name Wm. Riley
13. Birthplace Ill.

MOTHER
14. Maiden Name Angeline Chapman.
15. Birthplace Ill.

16 (a) Informant Fred Wellman
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Memorial Cem.
Location
18 (a) Funeral director Mary M. Wiedefeld
(b) Address 501 E. 33rd St.
19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946 at 6:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1946 to 2/13 1946 and that I last saw h[illegible] alive on 2/13 1946

Immediate cause of death	Duration
Fatty Embolism	
Due to Fract. of Rt. Tibia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-2-46 at P. M
(c) Where did injury occur? 2401 Freemount Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? [illegible]
(e) Means of injury Fell down steps in home

23. Signature Dudley Phillips
Address Md. Steil. Hosp. Date signed 2/13/46

Per. Benedict Statistic M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G37490 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 Dolphin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA H. LELAND

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife LeRoy L. Leland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1862

8. AGE: Years	Months	Days	If less than one day
83	10	13 14	hr. min.

9. Birthplace Worcester, Mass.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert Nathaniel Holmes
13. Birthplace Worcester, Mass.

MOTHER
14. Maiden Name Sarah
15. Birthplace Unknown

16 (a) Informant Miss Frances Laland
(b) Address 329 Dolphin St.

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1946 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11, 1946 to Feb. 14, 1946, and that I last saw h[illegible] alive on Feb. 14, 1946.

Immediate cause of death Circulatory failure meth coma — Duration 4 days
Due to Myocarditis — 7
Due to Arterio-Sclerosis with Hypertension — 7
Other Conditions Senile Dementia — One Year
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer M. D.
Address 3300 W. Northern Date signed 2/16/46

637491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

637491 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 N. Brice St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N Brice St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Lastner

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F ~~M~~ | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John H. Lastner, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Ruettinger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. John Lastner, son
(b) Address 529 N. Brice St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Feby 1946, at 12 30 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Sax death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Hetrick M.D. Medical Examiner

Date signed 15 Feb 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G37492 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline & Oliver

(c) Hospital or institution: St Josephs Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days) 66

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1733 N. Chester Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ANNIE E KIRSCHENHOFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Charles G. Kirschenhofer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1880

8. AGE: Years	Months	Days	If less than one day
66	0	12	hr. min.

9. Birthplace Penna.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Casper Glaser

13. Birthplace Germany

MOTHER

14. Maiden Name Clemantina Brandt

15. Birthplace Germany

16 (a) Informant Mr. Charles G. Kirschenhofer

(b) Address 1733 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/46 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

FEB 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1946 at 8:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22, 1946 to Feb. 14, 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
C. Resp failure	
LOBAR PNEUMONIA BILATERAL	
Due to	
Due to ARTERIO SCLEROTIC H. DISEASE	
Other Conditions CORONARY ARTERY DISEASE	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: SAME as above

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John B Lerella M. D.

Address St Jos Hosp Date signed 2-15-46

G37493 BALTIMORE CITY HEALTH DEPARTMENT G37493

CERTIFICATE OF DEATH 131B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 Laurens St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Laurens St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James (H.) P. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-6480

4. Sex: Male | 5. Color or race: Col- | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henretta Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/75

8. AGE: Years 71 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace St. Mary's Co., Md. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Lunch Room

FATHER 12. Name William Thomas

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Thomas

15. Birthplace Md.

16 (a) Informant Robert Thomas

(b) Address 1404-C-St. N.E. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Arbutus - Md.

18 (a) Funeral director Charles R. Law

(b) Address 802 Mad. Ave.

19 (a) FEB 15 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1946 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Chronic Nephritis

Due to

Other Conditions Cerous Tuberculosis Pneumonia, right.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Fratcher M.D.
Medical Examiner.

Date signed 2-13-46

131B

G37494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G37494

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Harrisburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 - State St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Col. William O. Hickok

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife 9-24-74

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 71 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Hickok

13. Birthplace Pa.

MOTHER 14. Maiden Name Mary Kerr

15. Birthplace Pa.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)

(c) Cemetery or crematory

Location Harrisburg Pa

18 (a) Funeral director William H. Deckenbach Sons

(b) Address 2nd + Peffer Streets

19 (a) FEB 16 1946 (Date rec'd by registrar) (b) Wellington K. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15-1946 at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1945 to 2-15 1946 and that I last saw h[illegible] alive on 2-15 1946.

Immediate cause of death: Respiratory failure — Duration

Due to Pneumonia

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of stomach

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard F. Kieffer

Address Johns Hopkins Hospital Date signed 2/15/46

VS 150

G37495 McCRACKEN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G37495 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Dorsey ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo McCracken
3 (b) If woman, name wife | 3 (c) Social Security Account No.
4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-16-95
8. Age: Years 50 | Months | Days | If less than one day: hrs. min.
9. Birthplace (State, county, and city)
10. Usual Occupation Waterman
11. Industry or business
12. Name of father Theodore McCracken
13. Birthplace Pa.
14. Maiden name of mother Catharine Mayer
Birthplace Pa
15. Informant
Address [illegible]
17 (a) Buried (b) Date thereof 1-18-46 (month) (day) (year)
(c) Cemetery or crematory Date of Plesey
Location Newport, Del.
18 (a) Funeral director Foley & Foley Inc
(b) Address 2445 E. Oliver St
19 (a) (Date rec'd by registrar) (b) Washington Blvd

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15- 1946 at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3- 1945 to 2-15- 1946. and that I last saw h. alive on 2-15- 1946.

	Duration
Immediate cause of death: Circulatory Collapse	4 hrs
Due to Portal Cirrhosis	4-5 mos
Due to	
Other Conditions Abscess Stomach Wall	

(Include pregnancy within 3 months of death)
Date of operation 12/13/45 12/20/46
Major findings of operation: Portal Cirrhosis. Stomach Wall Abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. E. Conser III M. D.
Address Union Memorial Hospital Date signed 2/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use the word unknown where the information cannot be correctly given. Please give street address. Physician please write legibly and correct age is especially important.

VS 150

G37496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G37496

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4808 Palmer Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Mon

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4808 Palmer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Schwartz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine Barron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1877

8. AGE: Years 68 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace Manhattan, N. Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER 12. Name Jacob Schwartz

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Josephine Schwartz

(b) Address 4808 Palmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day) (year)

(c) Cemetery or crematory Green Mount Cemetery Baltimore Md

Location

18 (a) Funeral director Lorman Bros

(b) Address 5025 Park Heights Ave

(c) FEB 16 1946 (Date rec'd by registrar) (d) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1946 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Feb 15 1946 and that I last saw h[illegible] alive on Feb 15 1946.

	Duration
Immediate cause of death: Carcinoma Stomach	Dec 1944
Due to	
Due to	
Other Conditions: Arteriosclerosis Heart Disease	Dec 1944

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Lorman M. D.

Address 5015 Park Heights Ave Date signed 2-15-46

VS 150

637197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 637197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 E Fuston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 E Fuston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John E Ambrose

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1876

8. AGE: Years	Months	Days	If less than one day
69	3	9	hr. min.

9. Birthplace Cockeysville Md
(Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business Hotel

FATHER
12. Name Louis A Ambrose
13. Birthplace Balto Co. Md

MOTHER
14. Maiden Name Mary Swartz
15. Birthplace Baltimore Co. Md

16 (a) Informant Mrs Bertha A Ambrose
(b) Address 706 E Fuston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

FEB 16 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from about 1938 to Feb 14 1946 and that I last saw he alive on Feb 14 1946

	Duration
Immediate cause of death Cerebral Hemorrhage	2 days
Due to arteriosclerosis & HD.	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death).
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gustav Hochstein M. D.
Address 888 W. Lombard St. Date signed 2/15/46

VS 150

(over)

X

G37498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

G37498 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C (b) County
(c) City or town Albemarle (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hubert E. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-04

8. AGE: Years 41 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Manager Clothing Store

11. Industry or business

FATHER 12. Name H. S. Smith
13. Birthplace N.C.

MOTHER 14. Maiden Name Ada Lyton
15. Birthplace N.C.

16 (a) Informant Estelle
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)
(c) Cemetery or crematory Albemarle
Location Albemarle N.C.

18 (a) Funeral director Tilson Co Inc
(b) Address 1214 Eutaw St

19 (a) FEB 16 1946 (Date rec'd by Registrar) (b) Huntington Williams Assistant

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1946 at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1946 to Feb 15 1946 and that I last saw h alive on Feb. 15 1946.

Immediate cause of death Uremia — Duration 2 wks

Due to Hypertensive cardiovascular disease — Duration 6 yrs

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmed diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Rustner M. D.
Address Johns Hopkin Hosp. Date signed 2-15-46

G37499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37499 Registered No.

MARGIN RESERVED — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 Lake Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Lake Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Lawson Todd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jason A Todd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1858

8. AGE: Years 87 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Crisfield Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Noah Lawson
13. Birthplace Crisfield Md

MOTHER
14. Maiden Name Nancy Tawes
15. Birthplace Crisfield Md

16 (a) Informant Mrs Charles H McGuigan
(b) Address 2222 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Jr
(b) Address 1217 E. Paul St

19 (a) FEB 16 1946 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Feb 15 1946, and that I last saw h alive on Feb 15 1946.

Immediate cause of death
(1) Diabetes Mellitus — Duration 7
(2) Hemiplegia — 3 days
Due to
Due to
Other Conditions Hypertension Cord. — 3 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. A. Daly
Address 5 Medical Arts Bldg Date signed Feb 15/46

VS 150

G37500
OWE-90253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a

Registered No. G37500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Shatcoat Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Emma Grace Pitts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2-1924

8. AGE: Years	Months	Days	If less than one day
22	1	15	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Pitts
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Owens
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Lantern Rd.

18 (a) Funeral director Samuel W. Gray & Son
(b) Address 638 N. Fulton Ave

19 (a) FEB 16 1946 (Date rec'd by registrar) (b) Waiting for Medical Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1946 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from February 15-46 to Feb. 15 1946 and that I last saw h... or alive on Feb. 15 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic heart disease Mitral stenosis & insuff.	
Due to Aortic " " "	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M Davis M. D.
Address B. C. H. Date signed 2-15-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37501 Registered No. 132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4108 Chatham Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Chatham Road (If rural give location)
(e) Citizen of foreign country No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lula J. Taylor

3 (b) If veteran, name war ****
3 (c) Social Security Account No. ****

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Griffin Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1875

8. AGE: Years 70 | Months 2 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: James Thomas Walter
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Anna Matilda Floyd
15. Birthplace: Virginia

16 (a) Informant: Mrs. Margaret Zorn
(b) Address: 4108 Chatham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18, 46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: Geo. W. Little
(b) Address: 2700 Edmondson Ave.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

FEB 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 14 1946, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to Feb 14 1946 and that I last saw h alive on Feb 12 1946

	Duration
Immediate cause of death: Pulmonary Edema	4 Hrs
Due to: Hypostatic Pneumonia	10 days
Due to: Carcinoma of uterus	1 Yr
Other Conditions: Coronary Sclerosis	3 Yrs

(Include pregnancy within 3 months of death)
Date of operation: ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. D. Jarrad M. D.
Address: 8106 Reisterstown Rd Date signed: Feb 14 46

X

G37502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G37502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bettie G. Byrum

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife James Byrum
6 (c) If alien, give citizenship ~~country~~

7. Birth date of deceased (mo., day, yr.) Mar 16. 1874

8. AGE: Years	Months	Days	If less than one day
71	10	29	hr. min.

9. Birthplace Herford Co. N.C.
(Town, county and state)
10. Usual Occupation Rooming House Operator
11. Industry or business

FATHER
12. Name Jas Copeland
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace N. C.

16 (a) Informant Nicholas Byrum
(b) Address 1126 Wilmot Court

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Memorial
Location Taylor Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Rd.

19 (a) FEB 16 1946 (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14- 1946, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Due to Thrombosis

Other Conditions Mural Thrombosis; Myocardial scarring.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 2-14-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G37503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Rayman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Rayman ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James P. Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Annie B. Kelly
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) December 11, 1864

8. AGE: Years	Months	Days	If less than one day
81	2	4	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Edward Kelly
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Annie B. Kelly
(b) Address 4206 Rayman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1946, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to 2/15 1946 and that I last saw h alive on 2/15 1946.

Immediate cause of death	Duration
Ch. Myocarditis	12 years
Due to: Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O S Harding
Address 4810 Belair Rd Date signed 2/19/46

VS 150

FEB 16 1946 Registrar of Vital Statistics, Md.

G37504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G37504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Etting St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary H. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm H. Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1862

8. AGE: Years 84 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alfred Price
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Fannie C. Evans
15. Birthplace Balto. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave. Baltimore, Md.

19 (a) FEB 16 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1946 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1946, to Feb 13 1946 and that I last saw h[illegible] alive on Feb 12 1946

Immediate cause of death

(a) Pleurisy Cardiac Renal Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. J. Fletcher

Address 1 yrs Pa Ave Date signed 2/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135a

G37505 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1923 Hope~~ Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Hope Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN KITSON

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-03-9080

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine Kitson
6 (c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1873

8. AGE: Years	Months	Days	If less than one day
72	11	24	hr. min.

9. Birthplace: Germantown, Pa. (Town, county, and state)
10. Usual Occupation: Printer, Retired 7 Yrs
11. Industry or business

FATHER
12. Name: James Kitson
13. Birthplace: England

MOTHER
14. Maiden Name: Sally Broadbelt
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Thomas Kitson
(b) Address: 1923 Hope Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-46 (month) (day) (year)
(c) Cemetery or crematory: Orems Cemetery
Location: Essex, Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 16 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to Feb 14 1946, and that I last saw h/ m. alive on Feb 14 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary heart disease	
Due to Myocardial infarction	
Other Conditions Hypertension pneumonia	

(Include pregnancy within 3 months of death)
Date of operation Jan 29, 1946
Major findings of operations: Contracted bladder + cystitis
of autopsy: Coronary Heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis H. Jaffe M. D.
Address Sinai Hospital Date signed Feb 14 1946

VS 150

TANKIN X

637506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

637506

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 3627 E. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lee Nash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Nellie Nash nee Cole (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 8 - 1908

8. AGE: Years	Months	Days	If less than one day
(37) 38	8	5	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Balto Transit Co.

FATHER
12. Name Lee Nash
13. Birthplace N. C.

MOTHER
14. Maiden Name Lettie Porter
15. Birthplace N. C.

16 (a) Informant Mrs. Notral Ramsey
(b) Address 1509 Gregory Ave, Balto 24-2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director John G. Connelly
(b) Address 414 Eastern Ave. Ext.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB [illegible] Funeral for Williams, M.D.

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1946 at 4:0 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of neck with perforation of large blood vessels.

Due to

Other Conditions Massive thoracic hemorrhage.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-12-46 11:45 P.M.
(b) Where did injury occur? 3627 E. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature Benedict Skiotarelic M.D.
Medical Examiner.
Date signed 2/13/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Space reserved for binding.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

637507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 S. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2t
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1411 S. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOSEPH G. STEWART

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Daisy M. Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1877

8. AGE: Years	Months	Days	If less than one day
68	3	6	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Hopkins Savings Bank

FATHER
12. Name Joseph B. Stewart
13. Birthplace Balto., Md

MOTHER
14. Maiden Name Eliza A. Voltz
15. Birthplace -

16 (a) Informant Mrs. Daisy M. Stewart
(b) Address 1411 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)

Date of copy (Print) Registrar

FEB 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1946, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1941 to 2/13 1946.
and that I last saw h alive on 2/13 1946

Immediate cause of death	Duration
Acute Cardiac failure	2 days
Due to Cardiovascular Renal Disease	5 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G Lankenau M. D.
Address 1629 Washington Blvd Date signed 2/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37508 /

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /159

Registered No. G37508

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3929 Poland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3929 Poland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Tennyson.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1946.

8. AGE: Years	Months	Days	If less than one day
—	—	—	½ hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Wm. M. Tennyson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Lillian V. Fowble
15. Birthplace Maryland.

16 (a) Informant Wm. M. Tennyson
(b) Address 3929 Poland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Edmund P. Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) ... (b) ...
(Date received by Registrar) Registrar

FEB 15 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1946, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1946 to Feb 15 1946 and that I last saw h[illegible] alive on 2/15 1946

Immediate cause of death ... Duration
Pneumatizing Cystic
Due to Liver 4 hours
Due to Fall.
Due to ...
Other Conditions ...
(Include pregnancy within 3 months of death)

Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 2020 E. Chase Date signed 2/16/46

SAUNDERS

637509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 09

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 Hanover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Saunders

3 (b) If veteran, name war — | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1879

8. AGE: Years 66 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Janitoress

11. Industry or business School System

FATHER 12. Name Joseph Gross
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Blackstone
15. Birthplace Md

16 (a) Informant Elizabeth Taylor
(b) Address 702 Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 106 W Montgomery St

19 (a) Feb 16 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/1946 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Feb 13 1946 and that I last saw her alive on Feb 13 1946.

	Duration
Immediate cause of death Acute Cardiac Dilatation	1 day
Due to Chr. Hypertensive-Cardiac Disease	about 7 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Haines, M. D.
Address 607 W. Hamburg St Date signed 2/15/46

VS 150

G37510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G37510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 E. 27th St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Do 9
(e) Length of stay in Baltimore (yrs., mos., or days) — ? —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 E. 27th. St (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Ellsworth Eplar (ELMER ELLSWORTH EPLER)

3 (b) If veteran, name war — ? —

3 (c) Social Security Account No. — ? —

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1946 at 1 30 P.M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowered

6 (b) Name of husband or wife Margaret Eplar
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About-1886

8. AGE: Years	Months	Days	If less than one day
Abt 60	?	?	hr. min.

9. Birthplace Shamokin Pa.
(Town, county, and state)

10. Usual Occupation Plumber
11. Industry or business Plumbing

FATHER
12. Name E. E. Eplar Sr.
13. Birthplace Penna

MOTHER
14. Maiden Name — ? —
15. Birthplace Penna

16 (a) Informant Miss Emma Lee
(b) Address 10 Bialop's Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)
(c) Cemetery or crematory Morland Mem'l Pk. New Location Parkville Balto Co.

18 (a) Funeral director Sherwin Morgan Co.
(b) Address 1018 Madison Ave.

19 (a) FEB 16 1946 (Date received by registrar) Hastings for Williams, M.D. Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary embolism following operative procedure on bladder and prostate.

Other Conditions Infected surgical — pubic operative incision.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 2/14/46.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G37511

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 S. KENWOOD AVE.
(c) Hospital or institution: 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 S. KENWOOD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET F. ROSE

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife ABEL ROSE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 24 1882

8. AGE: Years	Months	Days	If less than one day
64	0 1	22	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation MIDWIFE
11. Industry or business FOR SELF

FATHER
12. Name HENRY MILLER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ROSA CURTIS
15. Birthplace VIRGINIA

16 (a) Informant GERTRUDE GEBHARDT (DAUGHTER)
(b) Address 814 S. KENWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 18/46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Scilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) FEB 14 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH FEB. 15 1946, at 3/15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945 to 2-15 1946 and that I last saw h. alive on 2-15 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertensive Cardiovascular Disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ralph H. Lankastr
Address 6719 Harrington Road signed 2/16/46

VS 150

G37512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G37512 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 Etting St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Hudgins

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0331

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Adelia Hudgins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/1904

8. AGE: Years 41 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Alexandria, Va. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER 12. Name John H. Hudgins

13. Birthplace Alexander Va.

MOTHER 14. Maiden Name Anderson

15. Birthplace Alexander Va.

16 (a) Informant Cecilia R. Hudgins

(b) Address 2424 Etting St

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-16-46 (month) (day) (year)

(c) Cemetery or crematory Catholic Mount Pr

Location Balto. Md.

18 (a) Funeral director Archibald C. Haddix

(b) Address 2d & M Caroline Sts.

19 (a) (Date received by Local Registrar) (b) Registrar

FEB 10 1946

VS 150

Hunting for Witness

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1946, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1946, to 2-13 1946, and that I last saw h.im alive on 2-13 1946.

Immediate cause of death Uremia — Duration 4 weeks (history)

Due to Malignant Hypertension & Nephrosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Date signed 2/14/46

S.S. Oliver H. Perry - Ft. Covington

G37513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G37513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [redacted] (b) County
(c) City or town Willowbrook (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 N. 129th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank W. Manspeaker

3 (b) If veteran, name war

3 (c) Social Security Account No. 563-10-3579

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3rd 1906

8. AGE: Years 40 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Salem Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Albert G. Manspeaker
13. Birthplace Penna

MOTHER 14. Maiden Name Mary Wren
15. Birthplace Salem Ohio

16 (a) Informant Jennette Manspeaker
(b) Address 6718 Marbrisa Avenue Govans Park Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb 16 1946 (month) (day) (year)
(c) Cemetery or crematory Cremation Laudon D/R
Location Frederick Road

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date rec'd by registrar) (b) Huntington Hollins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1946 at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Atherosclerosis of Coronary

Other Conditions Old myocardial infarct.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D. Medical Examiner.
Date signed 2-13-46

FEB 16 1946

DVS-151

X

637514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

637514 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor 2 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 872 Carroll St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary E. Kelly

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1870

8. AGE: Years	Months	Days	If less than one day
76 yrs.	1		hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Wm. Farrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Kathryn Smith
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Fred Rd Baltimore Co.
18 (a) Funeral director John J Gowan Son
(b) Address 901-903 Hollins St.
19 (a) (Date rec'd by Registrar) (b) Thurlow Williams, M.D. Registrar

FEB 19 1946

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15th 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to Feb 15 1946, and that I last saw her alive on Feb 13 1946.

Immediate cause of death	Duration
(a) Acute Dilatation Heart	1 day
Due to (b) Chronic Myocarditis	5 yrs
Due to (c)	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E G Ill Hall M. D.
Address 1631 E. North Av Date signed 2-16-46

G37515

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 110 B

Registered No. G37515

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Essie Williams
6 (c) If alive, give age living years

7. Birth date of deceased (mo., day, yr.) 12/24/1899

8. AGE: Years	Months	Days	If less than one day
46 45	1 2	22	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Shipyard worker
11. Industry or business

FATHER
12. Name Simon Williams
13. Birthplace Deceased

MOTHER
14. Maiden Name Sarah Williams
15. Birthplace

16 (a) Informant Essie Williams
(b) Address 819 Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19, 1946 (month) (day) (year)
(c) Cemetery or crematory W. H. Autumn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 16 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1946, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22/45 19..., to 2/15/46 19..., and that I last saw him alive on 2/15/46 19...

Immediate cause of death	Duration
Respiratory failure	
with Heart failure & Operative shock	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/15/46
Major findings of operation: Calcified thickened pleura with lung abscess
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. T. Bailey M. D.
Address Mercy Hosp Date signed 2/15/46

VS 150

G37516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G37516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** SOLOMON CHARLES HODDINOTT

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 716-12-3747

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Edith I. Hoddinott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1882

8. AGE: Years	Months	Days	If less than one day
63	6	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business P. R. R.

FATHER
12. Name John Hoddinott
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Martha Fogler
15. Birthplace Balto., Md.

16 (a) Informant Mr. Charles J. Hoddinott
(b) Address 3438 Mondawmin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS,
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

FEB 16 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/15 1946 at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1946 to 2/15 1946, and that I last saw h IM alive on 2/14 1946.

Immediate cause of death BRONCHO-PNEUMONIA — Duration 12 HRS.

Due to PULMONARY CONGESTION

Due to RIGHT HEART FAILURE AND EMPHYSEMA

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: BRONCHOPNEUMONIA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M.D.
Address Linden & Madison; Date signed 2/15/46

Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

637517 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1960 N. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1960 N. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Capanna Trapani

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jesse Trapani

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1888

8. AGE: Years 57 Months 4 Days 23 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Domenico Capanna
13. Birthplace Italy

MOTHER
14. Maiden Name Clementina
15. Birthplace Italy

16 (a) Informant Husband
(b) Address 1960 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18, 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2518 E. Baltimore St

19 (a) (Date received by local registrar) (b) Registrar

FEB 16 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14th 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1940, to Feb. 14 1946, and that I last saw her alive on Jan. 14 1946.

Immediate cause of death	Duration
Coronary Occlusion	1 hour
Due to Arterial hypertension and Arteriosclerosis	6 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cusano M. D.

Address 514 Drury Lane Date signed 2/15/46

G37518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37518 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 N Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 N Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles G Sprecher Sr

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Grace V Sprecher
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 12 1868

8. AGE: Years	Months	Days	If less than one day
77	6	3	hr. ____ min.

9. Birthplace Washington County (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Philip Sprecher
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Eckman
15. Birthplace Maryland

16 (a) Informant Mrs Martha C Wright
(b) Address 3324 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave Balto

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 16 1946 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1946 11.20AM 19__ at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Feb. 1946 and that I last saw h[illegible] alive on 2/15/1946

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerotic cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. B. Stevens M.D.
Address 3400 Eastern Ave Date signed 2/15/46

Huntington Williams, M.D.

L. B. Stevens

G37519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

G37519 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 Brabant Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Brabant Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry H. Beneze

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Sophia A. Beneze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1879

8. AGE: Years	Months	Days	If less than one day
66	8	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation President, Murrill & Kni[illegible]er
11. Industry or business Employee's Co. Retire[illegible]

FATHER
12. Name John Beneze
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. Ruth M. Garvey
(b) Address 5310 Brabant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Fredpricks & Co
(b) Address 1200 Lombard

19 (a) FEB 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1946, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Feb 14 1946 and that I last saw him alive on Feb 13 1946.

Immediate cause of death	Duration
Generalized Metastasis	
Due to Carcinoma of Rectum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas S. Bowyer M. D.
Address Med Arts Bldg Date signed 2-15-46

VS 150

X

G37520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37520 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 S.Fagley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 S.Fagley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W.Doulong

3 (b) If veteran, name war	3 (c) Social Security Account No. 216-01-7467

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Bertha B.Waldman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.13,1900

8. AGE: Years	Months	Days	If less than one day
45	3	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Tool Repairman
11. Industry or business General Motors Corp.

FATHER
12. Name Frederick P.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Amanda Awrele
15. Birthplace Baltimore Md.

16 (a) Informant Bertha B.Doulong
(b) Address 614 S.Fagley St.

17 (a) Burial (b) Date thereof 2/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) FEB 16 1946 (b) Wm. J. Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14- 1946, at 6:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1945 to 2-14 1946, and that I last saw h~~im~~ alive on 2-13 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 days
Due to generalized arterio sclerosis	?
Malignant Hypertension	?
Due to chr. Myocarditis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Doulong M. D.
Address 3218 Eastern Av Date signed 2-16-46

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G37521
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1,
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Eliza Arrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1873

8. AGE: Years 72 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Milton Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Tena Jordan
15. Birthplace Va.

16 (a) Informant Ecca Gholson
(b) Address 1512 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A A County Md.

18 (a) Funeral director Wm. Robert C. Elliott & Son
(b) Address 1129 N. Carrie St.

19 (a) 2-17 1946 (Date received by registrar) (b) Catherine Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12- 1946, at 1-P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3- 1946, to 2-12- 1946, and that I last saw h[illegible] alive on 2-11- 1946

Immediate cause of death Cardio Renal Vascular Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Garnett M. D.
Address 611-N. Carrie Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

637522
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Georgian Court Apts
(c) Hospital or institution: 2520 Linden Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days): 13
(e) Length of stay in Baltimore (yrs., mos., or days): 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Georgian Court Apts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Lizzie Rosen

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: ~~Nate~~ Nathan
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Feb, 17, 1882

8. AGE: Years	Months	Days	If less than one day
63	11	29	hr. min.

9. Birthplace: Russia
(Town, county, and state)
10. Usual Occupation:
11. Industry or business: House Work

FATHER
12. Name: Frank Bagedonow
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rose ?
15. Birthplace: Russia

16 (a) Informant: Mr Sidney Rosen
(b) Address: 3501 Holmes Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb, 17, 1946 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cem
Location: 3600 E Baltimore St

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) FEB 17 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1946, at 6.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1933 19 to 2/15 1946, and that I last saw h~~er~~ alive on 2/14 1946

Immediate cause of death	Duration
Coronary Sclerosis	yrs
Due to: Chronic Arthritis	
Due to:	
Other Conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature:
Address: 2904 Reisterstown Rd Date signed: 2/16/46

VS. 150

94a

G37523 — BALTIMORE CITY HEALTH DEPARTMENT — G37523 Registered No.

CERTIFICATE OF DEATH ✓ 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2318 W North Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Berkowitz

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-12-8536

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Nee Kline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1890

8. AGE: Years	Months	Days	If less than one day
56	1	14	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Abraham Berkowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Russia

16 (a) Informant Sarah Berkowitz
(b) Address 2318 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 8.20

20. DATE OF DEATH February 15 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1945 to Feb. 15 1946 and that I last saw him alive on Feb 15 1946.

Immediate cause of death	Duration
Uraemia	
Due to Chr. diffuse glomerular nephritis	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Sheldon Eastland M.D.
Address 1124 E. N. Ave Baltimore Md Date signed 2/16/46

VS 150

Form Williams, MD

J. Sheldon Eastland M.D.

G37524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37524 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves.
(c) Hospital or institution: Levindale Hebrew Home - Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring + Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Matchett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER 12. Name

13. Birthplace Russia

MOTHER 14. Maiden Name

15. Birthplace Russia

16 (a) Informant Henry N. Matchett

(b) Address 3501 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-46 (month) (day) (year)

(c) Cemetery or crematory Pikesville

Location

18 (a) Funeral director Jack Levin Jrd

(b) Address 1439 E. Balto St

19 (a) 2-17-1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1941, to 2-16 1946 and that I last saw h[illegible] alive on 2-16 1946.

Immediate cause of death	Duration
Chr. card. vas. disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin M.D.

Address Levindale Date signed 2/16/46

VS 150

G37525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G37525 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 No Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1601 No Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Yehuda Lab

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses Kturosky
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Samuel N Snyder
(b) Address 1701 Moreland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-46 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd
Location

18 (a) Funeral director Jos Lewis Inc
(b) Address 1439 E Baltimore St

19 (a) 1946 (Date received by registrar) (b) Registered No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15- 1946 at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Aug 1945 to 15 Feb 1946 and that I last saw her alive on 14 Feb 1946

Immediate cause of death Squamus cell Carcinoma right side of face — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8 Sept. 1945

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur D Swinehart M. D.

Address Medical Arts Bldg Date signed 16 Feb 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G375526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G375526 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 951 Brooke Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3/1
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Abraham Friedman

3 (b) If veteran, name war

3 (c) Social Security Account No. 099-05-4563

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Greensboro Pa (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie
15. Birthplace Russia

16 (a) Informant Mrs. Natalie Pollard
(b) Address 2517 Linden Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Hebron Flushing L.I.
Location New York City

18 (a) Funeral director Jos. Lewis Sons
(b) Address 419 E. Balto St

19 (a) 2-17-1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15-1946, at 11:19 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to 2-13th 1946, and that I last saw him alive on 2-15th 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to coronary sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold H. Bix M. D.
Address 2516 Linden Date signed 2-17-46

VS 150

G37527

488235

G37527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Wilson

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Agnes
6 (c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): 10-11-85
8. AGE: Years: 60 Months: 4 Days: 4 If less than one day: hr. min.
9. Birthplace: Md.
(Town, county, and state)
10. Usual Occupation: Supervisor Baltimore City
11. Industry or business: City of Balto

FATHER
12. Name: Jesse Wilson
13. Birthplace: Md

MOTHER
14. Maiden Name: Va. Griffith
15. Birthplace: Md

16 (a) Informant: Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) FEB 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-15 1946 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-11-1946 to Feb-15 1946 and that I last saw him alive on Feb-15 1946.

Immediate cause of death: Aspiration of Stomach Contents — Duration: 10 minutes
Due to: Pneumonectomy — 2 days
Due to: Carcinoma of Lung — 3-4 months
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 2/14/46
Major findings of operation: Carcinoma of Lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Cauman III M. D.
Address Johns Hopkins Hospital Date signed 2/16

X Dr Cauman 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G37528 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1738 Caton Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) √
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1655 Kingsway Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Trad Murphy

3 (b) If veteran, name war WW | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Martha A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1866

8. AGE: Years 89 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Harford Co Md (Town, county, and state)

10. Usual Occupation Salesman Retired

11. Industry or business

FATHER
12. Name William Murphy
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Mary Mitchell
15. Birthplace Harford Co Md

16 (a) Informant Ethel M Murphy
(b) Address 1655 Kingsway Terrace

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 2 19 46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director William Cox Inc
(b) Address 1219 E Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1946, at 9 20 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/14 1946 to 2/16 1946, and that I last saw h[illegible] alive on 2/16 1946.

Immediate cause of death Arteriosclerotic Cardiovascular Renal Disease — Duration 2

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L Blevins M.D.
Address 1206 E Preston St Date signed 2/16/46

VS 150

Hunting for Williams, Md

X

G37529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37529 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 Thames Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Thames Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ZBOROWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 1, 1872

8. AGE: Years	Months	Days	If less than one day
73	5	13	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michael Dabrowski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Lentz
15. Birthplace Poland

16 (a) Informant Mr. Albert Zborowski
(b) Address 1802 Thames Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Ave

19 1946 (Date rec'd by registrar) (b) Livingston Hilliard, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1946 at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1946, to Feb 14 1946, and that I last saw h alive on 19

Immediate cause of death	Duration
Hemiplegia	1 day
Due to Chronic Myocarditis	2 yrs
Due to Hypertension	2 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Szperbecki M. D.
Address 1802 Eastern Date signed 2-18-46

John V. Szperbecki

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 Harlem ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward F. Crowding

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-4152

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rachael C. Crowding
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1873

8. AGE: Years	Months	Days	If less than one day
70	5 6	29	hr. min.

9. Birthplace Still Pond Kent Co. Maryland
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Haulage Bus.

FATHER
12. Name Jacob Crowding
13. Birthplace Kent Co. Maryland.

MOTHER
14. Maiden Name Annie Robinson
15. Birthplace Kent Co. Maryland

16 (a) Informant Mrs. Edward Crowding
(b) Address 4668 Marble Hall Rd. Balto.

17 (a) Burial (b) Date thereof 2/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location St. Paul Kent Co. Maryland

18 (a) Funeral director Marvin V. Williams
(b) Address Chestertown Maryland.

19 (a) FEB 17 1946 Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10/46 19 to 2/13/46 19, and that I last saw h[illegible] alive on 2/13/46 19

	Duration
Immediate cause of death Respiratory failure	
Due to Subarachnoid hemorrhage	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 604 N. Monroe St. Date signed 2/15/46

BALTIMORE CITY HEALTH DEPARTMENT

G37531

CERTIFICATE OF DEATH 94a

G37531

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E 23½ St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace V

16 (a) Informant Emma Harris Wife
(b) Address 300 E 23½ St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2 17 46 (month) (day) (year)
(c) Cemetery or crematory Gloucester
Location Gloucester Va.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Feb 1946, at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William T Telfer M.D. Medical Examiner
Date signed 15 Feb '46

VS 151

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

G37532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G37532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Fawcett St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sister Mary Millicent (Nabers)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/1899.

8. AGE: Years 46 | Months 10 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Lee. (Town, county, and state)

10. Usual Occupation Nun.

11. Industry or business

FATHER 12. Name Frank Nabers
13. Birthplace Mass

MOTHER 14. Maiden Name Mary Dooley
15. Birthplace Lee

16 (a) Informant Hospital Records
(b) Address N. Fayette St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2/18/46. (month) (day) (year)
(c) Cemetery or crematory
Location Emmanuel Mass

18 (a) Funeral director J. J. Tobey Sons
(b) Address 218 Eight St.

1946 (Date rec'd by registrar) Thomas [illegible] Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1946, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1946, to 2/15 1946, and that I last saw h[illegible] alive on 2/15 1946.

Immediate cause of death Adynamic ileus — Duration 5 days.
Due to Post Operative (Pan hysterectomy)
Due to
Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation 2/7/46
Major findings of operation: Carcinoma of cervix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Adickes Jr. M. D.
Address Bon Secours Hosp. Date signed 2/15/46

G37533

BALTIMORE CITY HEALTH DEPARTMENT G37533 Registered No.

CERTIFICATE OF DEATH 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 N. Fulton ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Fulton ave
(If rural give location).
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Juanita Marcum

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 17, 1940

8. AGE: Years: 5 | Months: 11 | Days: 0 | If less than one day: hr. min.

9. Birthplace LA FOLLETTE TENN.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business None

FATHER
12. Name JAMES MARCUM
13. Birthplace TENN.

MOTHER
14. Maiden Name EDNA STANFORD
15. Birthplace TENN.

16 (a) Informant JAMES MARCUM
(b) Address 614 N. FULTON AVE

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof FEB. 17 1946 (month) (day) (year)
(c) Cemetery or crematory STOKES
Location LAFOLLETTE, TENN.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17, 1946, at 8 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1946, to Feb 17 1946, and that I last saw h PY alive on Feb 17 1946

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Canfield, M. D.
Address 722 N. Fulton Ave Date signed 2/17/46

G37534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37534 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 38th & Calvert Sts.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Bolton St., City 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Joseph Hamilton Thompson (Frances Elizabeth)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	

6 (b) Name of husband or wife Joseph C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1869

8. AGE: Years	Months	Days	If less than one day
76	10	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER 12. Name Truman Cross Shingluff
13. Birthplace Maryland
MOTHER 14. Maiden Name Anna R. Pilgrim
15. Birthplace Maryland

16 (a) Informant Mr. J. Truman Thompson (Son)
(b) Address 3802 Juniper Rd., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & P. Aves.

19 (Date received by registrar) B 13 1946 Harrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1946, at 3:09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1946, to Feb. 16 1946, and that I last saw h[illegible] alive on Feb. 16, 1946

Immediate cause of death	Duration
(a) Cardiac failure -	
left sided	
Due to (b) arteriosclerotic heart disease	
Due to (c) with	
Due to (d) auricular flutter	
Other Conditions Bronchopneumonia, Dilated, Liver Cirrhosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Speed III
Address Union Memorial Hosp. Date signed 2/18/46

VS 150

G37535

CWK-99228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 46D

G37535

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 60- 0- 25-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 N. Dukeland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Scheib (JOHN LESTER SCHEIB)

3 (b) If veteran, name war	3 (c) Social Security Account No. 711-07-1533

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20-1886

8. AGE: Years	Months	Days	If less than one day
60	0	25	hr. min.

9. Birthplace Maryland (Carroll Co.)
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Baltimore City

FATHER
12. Name Henry Scheib
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name Mary Sexton
15. Birthplace Maryland (Balto.)

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2/18/46
(Burial, cremation, or removal) (month, day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director William Tickner Sons
(b) Address North & Calvert

19 (a) 2-16-46 (b) Clifton Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH February 15 1946 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 46 to Feb. 15 46, and that I last saw h... alive on Feb. 15 46.

Immediate cause of death: Carcinomas of rectum & metastases to liver, — Duration
Due to Liver & retro-peritoneal nodes.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Cause

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Margaret McDonnell M. D.
Address B C H Date signed 2-16-46

VS 150

G37536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/17a

G37536 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Oakhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary-Pauline Porter (MARY PAULINE PORTER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Jefferson B. Porter
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1888

8. AGE: Years	Months	Days	If less than one day
57	6	4	********** hr. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Lee F. Ott
13. Birthplace West Virginia

MOTHER
14. Maiden Name Helen Jeniaming
15. Birthplace Georgetown, Washington D. C.

16 (a) Informant Mr. Jefferson B. Porter
(b) Address 1900 Oakhill Ave.

17 (a) Burial (b) Date thereof 2/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathederal
Location Baltimore Maryland

18 (a) Funeral director C. B. Wilbert & Son
(b) Address 1300 Eutaw Place.

19 (a) FEB 17 1946 (b) Wm. Lee Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1946, at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1946 to 2/13 1946, and that I last saw her alive on 2/13 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerosis	
Due to	
Other Conditions Gastric Ulcer, Uterine Tumor	

(Include pregnancy within 3 months of death)

Date of operation 1/24/46
Major findings of operation: Gastric Ulcer, Uterine Tumor
Date of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Dennis
Address University Hospital Date signed 2/16/46 M. D.

G37537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37537 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pulaski & Raymond 5
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 N Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry R Lee

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	344-10-3610

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1882

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Robert Levy
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Ring
15. Birthplace Germany

16 (a) Informant Miss Sadie Levy
(b) Address 2113 N Smallwood St

17 (a) Cremation (b) Date thereof Feb 18 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loeden Park Cemetery
Location Frederick Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) FEB 18 1946 (b) Huntington Willis Register
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1946, at 3 P M (3a)

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1946 to 2-16 1946, and that I last saw him alive on 2-16 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Cardiovascular Disease & Uremia	
Due to	
Other Conditions Diabetes Mellitus Pyloric Obstruction due to ulcer (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Baltimore M. D.
Address WBGH Date signed 2-16-46

VS 150

0 93D

G37538 Perez

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G37538 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County [redacted]
(c) City or town Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 7 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Manuel Perez

3 (b) If veteran, name war: UNKNOWN

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: UNKNOWN

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years: 34 | Months | Days | If less than one day: hr. min.

9. Birthplace: UNKNOWN
(Town, county, and state)

10. Usual Occupation: SEAMAN

11. Industry or business

FATHER
12. Name: UNKNOWN
13. Birthplace: UNKNOWN

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: UNKNOWN

16 (a) Informant: MARTIME UNION RECDS.
(b) Address: FLEET & BROADWAY

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 18/46 (month) (day) (year)
(c) Cemetery or crematory: ST. JOHNS
Location: ELLICOTT CITY MD.

18 (a) Funeral director: Lilly & Zeiler Inc.
(b) Address: 403 S. WOLFE ST.

19 (a) FEB 18 1946 (Date rec'd by registrar) Kenneth Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1946, at 9.10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute cardiac failure

Due to: Chronic Rheumatic endocarditis (Mitral stenosis)

Other Conditions: Cardiac hypertrophy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Benedict Skatarsky M.D.
Medical Examiner.
Date signed 2-13-46

VS 151

G37539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G37539 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore - #6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4205 Raymar Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Albertson

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

Was a widow
6 (b) Name of husband: Not recorded
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1869

8. AGE: Years 76 | Months 8 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Thomas C. Derman
13. Birthplace Maryland

MOTHER
14. Maiden Name Belle Price
15. Birthplace Md

16 (a) Informant A. K. Yeaman
(b) Address 4205 Raymar Ave

17 (a) Removal (b) Date thereof 2/18/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Mausoleum~~: Glenwood Cemetery
Location: Waverly N. Y.

18 (a) Funeral director: William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) FEB 18 1946 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16-46 19..., at 9 1/8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28-46 19..., to 2-16-46 19..., and that I last saw HER alive on 2-16-46 19...

Immediate cause of death: Ca of Stomach c — Duration

Due to: bony metastases

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: C. H. Stedem Jr M. D.
Address: Mercy Hosp Date signed 2/16/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G37540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3413 Old York Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Old York Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W Adams

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Emma C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1872

8. AGE: Years 73 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Hollidaysburg Pa
(Town, county, and state)

10. Usual Occupation Caretaker, Municipal

11. Industry or business

FATHER
12. Name Wilson Adams
13. Birthplace Pa

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa

16 (a) Informant Jack Adams
(b) Address 3413 Old York Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)

(c) Cemetery ~~cremation~~ Grandview
Location Johnstown Pa.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) FEB 18 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1946, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Feb 17 1946 and that I last saw h alive on Feb 17 1946

Immediate cause of death

Chronic Myocarditis — Duration: indef

Due to

Due to

Other Conditions Arteriosclerosis — Duration: indef
Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1132 W 20th St Date signed Feb 17 46

VS 150

G37541 HEALTH DEPARTMENT—CITY OF BALTIMORE G37541

CERTIFICATE OF DEATH

1. PLACE OF DEATH Volunteers of America Hospital Registered No. 1610

CITY OF BALTIMORE: (No. 48 W Lexington St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME PHYLLIS ELIZABETH MARSH If U. S. Veteran specify WAR ...

(a) Residence: No. 1107 Overbrook Road - Apt. 12 St., Ward. Balto., Md.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	S

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Feb. 15, 1946

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	17 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Clarence Marsh

14. BIRTHPLACE (city or town) (State or country) Balto Md

MOTHER

15. MAIDEN NAME Mary Ebbert

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Mary Marsh
(Address) 1107 Overbrook Rd.

18. BURIAL, CREMATION, OR REMOVAL
Place Fredonia Date 2/18, 1946

19. UNDERTAKER Wilhelm Lord & Son
(Address) 2102 E. Pratt St.

20. FILED FEB 18 1946 Registrar Wilhelm Hartinger

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 16, 1946

22. I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1946 to Feb. 16, 1946

I last saw her alive on Feb. 15, 1946 Death is said to have occurred on the date stated above, at 9.30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Congenital Cerebral Ataxia	2/16/46
Other contributory causes of importance:	

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) I Leonard Yaffe M. D.

(Address) Volunteers of America Hospital

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 18 1946

G37542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37542

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Bolton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor F. Hellen (Hellen)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1869

8. AGE: Years	Months	Days	If less than one day
76/72	6	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas H. Hellen
13. Birthplace Md.

MOTHER
14. Maiden Name Letitia Small
15. Birthplace Md.

16 (a) Informant Mrs. Irene H. Read
(b) Address 913 69th Ave., Oak Lane, Phila., Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Greenmount & North Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 19 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Feb'y 1946, at 11:50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Hellen M.D. (Medical Examiner)
Date signed 15 Feb'y '46

VS-151

G37543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G37543 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Fairmount
(c) Hospital or institution: Maryland General Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Enclid
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Enclid Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Creamer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/1877

8. AGE: Years	Months	Days	If less than one day
68	7	25	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Agent Baggage Penna. R.R.
11. Industry or business

FATHER
12. Name Franklin Creamer
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary ??? Lear
15. Birthplace Balto.

16 (a) Informant Alice Creamer
(b) Address 4207 Enclid Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 20/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 2800 Frederick Ave

18 (a) Funeral director John O'Neill Sons
(b) Address 1600 Eutaw Pl.

19 (a) 2 18 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1946, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1946, to 2/17 1946, and that I last saw him alive on 2/17 1946

Immediate cause of death Bronchopneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 2/17/46

VS 150

G37544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G37544

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 Cedar Croft Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 Cedar Croft Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Evon

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma L. Mulligan
6 (c) If alive, give age: 74 years
7. Birth date of deceased (mo., day, yr.) 2/25/1863
8. AGE: Years 82 | Months 11 | Days 23 | If less than one day hr. min.
9. Birthplace: England (town, county, and state)
10. Usual Occupation: Retired Pullman Conductor
11. Industry or business

FATHER
12. Name: Henry Evon
13. Birthplace: England

MOTHER
14. Maiden Name: Sarah
15. Birthplace: England

16 (a) Informant: Walter Welsh
(b) Address: 219 Cedar Croft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)
(c) Cemetery or crematory: Spring Grove
Location: Cincinnati, Ohio

18 (a) Funeral director: John O. Mitchell & Sons
(b) Address: 1900 Eutaw Place

FEB 18 1946 (Date rec'd by registrar)
(b) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Feb 17 1946 and that I last saw h[illegible] alive on Feb 8 1946.

Immediate cause of death	Duration
Carcinoma Larynx	8 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Grant Edward. M. D.
Address Medical Arts Bldg Date signed 3/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37545

AB-99198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V1860

Registered No. G37545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Moye Myrick

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2- 1868

8. AGE: Years 77 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Va. Spotsylvania
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jerry or Jersey Farley
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Belcher
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19 1946 (month) (day) (year)
(c) Cemetery or crematory Family Cemetery
Location Camp Greek Md

18 (a) Funeral director Frederick S. Dyer
(b) Address 1200 W. Lombard St

19 (a) FEB 18 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1946, at 9.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1946 to 2-16 1946, and that I last saw h. alive on 2-16 1946.

	Duration
Immediate cause of death: Terminal bronchopneumonia	2 days
Due to: Intertrochanteric Fracture, Femur, left	7 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 141.2
(a) Accident, suicide, or homicide
(b) Date of occurrence 2-9-46 at M
(c) Where did injury occur? Baltimore, Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home ? While at work? no
(Specify type of place)
(e) Means of injury Fall down to floor.

23. Signature Thomas J. Orell M. D.
Address Balto. City Hosp. Date signed 2-17-46

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER Benedict Whitelaw M. D.

637546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133a

Registered No. 637546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1517 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ROSA BELLE LOBER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late John H. Lober

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1870

8. AGE: Years 75 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Reuben Bowers
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Greenwood
15. Birthplace Md

16 (a) Informant Mrs. Geo. A. Bowden
(b) Address 1516 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3861 Eudowick Rd

18 (a) Funeral director Harry H. Mitcher
(b) Address 4101 E. Monument Ave

19 (a) FEB 18 1946 (Date rec'd by registrar) (b) Huntington, Indiana, Ind. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1946 at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1946 to 2/14 1946, and that I last saw HER alive on 2/14 1946.

Immediate cause of death PNEUMONIA AND UREMIA — Duration 4 hrs.

Due to — Duration

Due to — Duration

Other Conditions — Duration none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place).
(e) Means of injury

23. Signature Charles W. Stewart, Jr.
Address Linden & Madison Date signed M. 2 D. 18/46

VS 150

X

G37547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1830

G37547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Grantley St.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Grantley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1881

8. AGE: Years 64 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Lewis
13. Birthplace

MOTHER
14. Maiden Name Ellen Garner
15. Birthplace

16 (a) Informant Walter A. Starr
(b) Address Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18 46 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location 3501 Frederick Rd.

18 (a) Funeral director Harry H. Kittle
(b) Address 4101 Edmondson Ave

19 (a) FEB 19 1946 (Date rec'd by Registrar) Hattie Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1946, at 11.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Feb. 15 1946, and that I last saw her alive on Feb. 15 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 10 hrs.

Due to: Hypertension — Duration: years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Yaffey MD

Address 3101 W Baltimore St Date signed FEB 18 1946

BALTIMORE CITY HEALTH DEPARTMENT 1946 G37548

CERTIFICATE OF DEATH

G37548 Registered No.

Stopping at Southern Hotel

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover Sts.
(c) Hospital or institution University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Conn (b) County
(c) City or town New London
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Walter Leffler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Edna Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1877

8. AGE: Years	Months	Days	If less than one day
about 68 69	-	-	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired Banker

11. Industry or business

FATHER
12. Name Albert E. Leffler
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Moseman
15. Birthplace Havre de Grace Md

16 (a) Informant Wm A. Leffler (Brother)
(b) Address Havre de Grace Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21-46 (month) (day) (year)
(c) Cemetery or crematory Upperco Cem
Location Perryman Md

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace Md

19 (a) FEB 18 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15th 1946 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelis M.D. Medical Examiner.
Date signed 2/15/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G37549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1370

Registered No. G37549

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315 S. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (if outside city or town limits, write RURAL and give town)
(d) Street No. 315 S. Stricker St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William F. Linton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Rosa William Linton
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 25-1869

8. AGE: Years	Months	Days	If less than one day
76	6	19	hr. min.

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation Retired R. R. Fireman
11. Industry or business Railroad

FATHER
12. Name John J. Linton
13. Birthplace Md

MOTHER
14. Maiden Name Mollie Forrester
15. Birthplace Md

16 (a) Informant Mrs. Rosa W. Linton
(b) Address 315 S Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Chas L. Bayne Jr
(b) Address 1512 Hollins St

19 (a) FEB 16 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1946, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 1, 1946, to Feb 14 1946 and that I last saw him alive on Feb 13 1946

Immediate cause of death: uremia — Duration 10 days

Due to chronic bilateral pyelo-nephritis; Left pyonephrosis — unknown

Due to chronic prostatic hypertrophy — 5 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen
Address 206 S. Gilmor Date signed 2-17-46 M. D.

X. RACUSIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 637550

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 Lauretta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Lauretta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle E. Lafferty

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James H. Lafferty
6 (c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.): Io/29/I894
8. AGE: Years 5I | Months 3 | Days I5 | If less than one day ____ hr. ____ min.
9. Birthplace: Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: Home

FATHER
12. Name: John Severn
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden Name: Margaret Brandenburg
15. Birthplace: Carroll Co. Md.

16 (a) Informant: Family
(b) Address: 2509 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or crematory: Morgan Chapel
Location: Morgan, Maryland

18 (a) Funeral director: James L. McCauley
(b) Address: I30 E. Fort Ave.

19 Date received by Local Registrar: FEB 18 1946 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1946 to Feb 14 1946, and that I last saw h[illegible] alive on Feb 14 1946

Immediate cause of death	Duration
Coronary Thrombosis	2 yrs
Due to Hypertensive Heart Disease	
Due to Essential Hypertension	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Albert Shankland M.D.
Address: 730 E. Lexington Date signed 2/15/46

93D

G37551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G37551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Frances Doulong

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Henry Doulong

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1867

8. AGE: Years 78 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Meisenhalder
13. Birthplace Germany

MOTHER
14. Maiden Name ? Schroder
15. Birthplace Germany

16 (a) Informant Mrs. Mariel Morrison
(b) Address 1209 N. Calvert St.

17 (a) Burial (b) Date thereof 2-18-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem
Location Baltimore Md.

18 (a) Funeral director Henry Sanders & Sons Inc
(b) Address North Ave. & Broadway

FEB 18 1946 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1946, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Feb. 16th 1946, and that I last saw her alive on Feb 15th 1946

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 days
Acting Pulmonia	5 days
Due to Diabetes Mellitus	2 years
Due to	
Other Conditions Carcinoma of breast	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Chatard M. D.
Address 1300 N. Calvert St. Date signed Feb. 16/46

VS 150

832 Chat. 2 ad.

G37552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G37552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood, Penna
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Overland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Elsie Oehring ELSIE LOUISE OEHRING

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles Christian
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 20, 1897

8. AGE: Years	Months	Days	If less than one day
48	6	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Julius Witzel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Geller
15. Birthplace Baltimore, Maryland

16 (a) Informant Charles F. Oehring
(b) Address 3017 Overland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) FEB 18 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1946, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1946 to 2-16 1946, and that I last saw her alive on 2-16 1946.

Immediate cause of death	Duration
Lobar pneumonia - rt	
Due to 2 left. Lower lobes	
Due to	
Other Conditions Leucopenia + Arsenic Splenectomy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George R. Callender M. D.
Address Univ. Hosp. Baltimore Date signed 2-16-46

VS 150

Released to Hosp — Med Exam Case

637553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 637553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 227 S. Eaton St
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S. Eaton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gupatoff
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22nd 1895

8. AGE: Years	Months	Days	If less than one day
50	10	24	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Jacob Yapatoff
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto., Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 18 1946 (b) Arrington Williamson
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1946 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1946 to 2-16 1946, and that I last saw h alive on 19

Immediate cause of death	Duration
cerebro - vascular accident, LEFT CEREBRUM	5 HOURS
Due to hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jules L Greene
Address Johns Hopkins Hospital Date signed 2/17/46

Rev. Benedict Skitarelic M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37554

GEORGE B. GILDENFENNEY

BALTIMORE CITY HEALTH DEPARTMENT 1946

CERTIFICATE OF DEATH

Registered No. G37554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Mura
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Padonia Road (If rural, give location)
(e) Citizen of foreign country? PADONIA No (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Gildenfenney

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1883

8. AGE: Years	Months	Days	If less than one day
62	8	3	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and State)
10. Usual Occupation Pullman Conductor
11. Industry or business

FATHER
12. Name Charles J. Gildenfenney
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Mary Ford
15. Birthplace Ireland

16 (a) Informant Mrs. Mary M. Knight
(b) Address Padonia Road Cockeysville

17 (a) Burial (b) Date thereof Feb. 20-1946
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Dulaney Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3601 Falls Road

19 (a) FEB 18 1946 (b) Lillington Williams M.D.
(Date received by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1946, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1946 to 2/14 1946, and that I last saw h[illegible] alive on 2/14 1946

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	2 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Callender / A.H. Hampton M.D.
Address Univ. Hospital Date signed 2-17-46

VS 150

G37555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61B

637355 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Stilson St.
(c) Hospital or institution Mrs Shriner's Home 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2340 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME James Thomas Lee Jones

3 (b) If veteran, name war None
3 (c) Social Security Account No. — ? —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Bella L. E. Jones
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 1 1863

8. AGE: Years 82 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Co. Md.
(Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business (retired)

FATHER 12. Name Oliver B Jones
13. Birthplace Montgomery

MOTHER 14. Maiden Name Mary Todman
15. Birthplace Unknown

16 (a) Informant Mrs Chas I Weiller (daughter)
(b) Address 2417 Eierton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Sherwood Memorial
(b) Address 1051 W Lafayette Ave.

FEB 18 1946 (Date rec'd by Registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1946, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Feb. 17 1946
and that I last saw h[illegible] alive on Feb. 17, 1946

Immediate cause of death	Duration
Carcinoma of Prostate	
Due to	
Due to	
Other Conditions Metastasis	

(Include pregnancy within 3 months of death)
Date of operation 1944 Johns Hopkins
Major findings of operation:
Autopsy? Not

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edith L. Levy M. D.
Address 2340 Eutaw Place Date signed 2/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G37556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G37556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 St. Johns Road
(c) Hospital or institution: Mrs Harvey's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 St Johns Rd
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie-Grace-Vanderveer

3. (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Dr. Jno. L. Vanderveer
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) May-24-1860
8. AGE: Years 85 | Months 8 | Days 21 | If less than one day hr. min.
9. Birthplace Brooklyn NY. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Thos. Baird
13. Birthplace New York

MOTHER
14. Maiden Name Mary Ann Mowbrey
15. Birthplace New York

16 (a) Informant Geo G. Vanderveer (son)
(b) Address Stevenson - Md
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-18-46 (month) (day), (year)
(c) Cemetery or crematory Greenmount
Location Baltimore
18 (a) Funeral director Stevens Morgue.
(b) Address 108 W Mont Ave.
19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1946, at 9 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 1939, to 2/17 1946, and that I last saw him alive on 2/16 1946

Immediate cause of death: Myocarditis Arterio-Sclerosis — Duration: Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Roody
Address 1403 Park ave Date signed 2/18/46 (M.D.)

VS 180

G37557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G37557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Jack Street Zone 25
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Jack Street -25-
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Martha Pauline Leisure

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Chrales Wm Leisure
6 (c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): July 1st 1868

8. AGE: Years: 77 | Months: 7 | Days: 15 | If less than one day: ..... hr. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Wesley Kemp
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden Name: Mary V Klein
15. Birthplace: Baltimore Maryland

16 (a) Informant: Mr Leisure
(b) Address: 305 Jack Street -25-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 19-46 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cemetery
Location: Gov Ritahie Highway Balto.

18 (a) Funeral director: Milton Schilling
(b) Address: 3914 S Hanover St-25-

19 (a) FEB 18 1946 (Date rec'd by Registrar) (b) ..... Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16th 1946, at 5.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Feb-16 1946, and that I last saw h[illegible] alive on Feb-16 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: Feb. 12-46
Due to: Arterio-Sclerosis
Cardio-Vascular Renal
Due to: .....
Other Conditions: .....

(Include pregnancy within 3 months of death)
Date of operation: .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: .....
(b) Date of occurrence: ..... at ..... M
(c) Where did injury occur? ..... (City or town) ..... (County) ..... (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Md (Specify type of place) While at work? .....
(e) Means of injury: .....

23. Signature: Paul Lubin M.D.
Address: 320 Patapsco Ave Date signed: 2/18/46

G37558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G37558

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Lawnview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Lawnview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Whiting Whitten, SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	

6 (b) Name of husband or wife. Mary S.

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1886

8. AGE: Years	Months	Days	If less than one day
59	11	24	hr. min.

9. Birthplace Boston Mass (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Bank

FATHER
12. Name Wm C. Whitten
13. Birthplace Boston Mass

MOTHER
14. Maiden Name Irene Hay
15. Birthplace Ireland

16 (a) Informant Mary S. Whitten
(b) Address 3116 Lawnview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19 46 (month) (day) (year)
(c) Cemetery or crematory Bells Church
Location Bells Pike

18 (a) Funeral director Agnes Slutz
(b) Address North Broadway

19 (a) (Delivered by undertaker) (b) Feb 19 1946 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 - 1946, at 2 50 P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shtarcke M.D. Medical Examiner.

Date signed 2-14-46

(over) X

Dr John Clift
5010 Greenleaf Rd
G37559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. G37559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4231 Nicholas Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4231 Nicholas Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret M. Ellinghaus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Nicholas J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1874

8. AGE: Years	Months	Days	If less than one day
72	-	5	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Edwin O'Leary
13. Birthplace Canada

MOTHER 14. Maiden Name Mary Fahey
15. Birthplace Maryland

16 (a) Informant Mrs. John Quinn
(b) Address 4231 Nicholas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Leuck
(b) Address 5305 Harford Road

FEB 18 1946 (Date rec'd by registrar) (b) Wm. Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 - 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Feb 16 1946, and that I last saw her alive on Feb 14 1946.

Immediate cause of death	Duration
Myocardial Insufficiency	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. V. Clift M. D.
Address 5010 Greenleaf Rd Date signed 2-17-46

637560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

637560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1924 Orleans St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John N. Schussler

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Schussler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1882

8. AGE: Years	Months	Days	If less than one day
64	0	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ---- Schussler
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth ---
15. Birthplace Pa.

16 (a) Informant Mrs. Margaret Schussler
(b) Address 1924 Orleans St.

17 (a) Burial (b) Date thereof Feb. 18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Balto. Md.

18 (a) Funeral director Philip Sterling Sons
(b) Address 2024 Orleans St.

19 (a) FEB 18 1946 (Date rec'd by Registrar) Sterling for William

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from December 4 1945 to Feb 14 1946 and that I last saw h alive on Feb 14 1946.

Immediate cause of death	Duration
Cirrhosis of the liver	3 mo.
Due to	
Due to	
Other Conditions Arteriosclerosis Hypertension	2 years.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Swidler M. D.
Address 1701 E. Fayette Date signed 2/16/46

VS 150

G37561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G37561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4513 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fehrman

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1879

8. AGE: Years	Months	Days	If less than one day
67	0	13	hr. min.

9. Birthplace London England
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Fehrman
13. Birthplace Germany

MOTHER
14. Maiden Name Meta --
15. Birthplace Germany

16 (a) Informant Mr. Frederick Fehrman
(b) Address 4513 Park Heights Ave.

17 (a) Burial (b) Date thereof Feb. 19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) FEB 18 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1946 to Feb 15 1946 and that I last saw him alive on Feb 15 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 5 hrs
Due to: Arterio Sclerosis — 10 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4309 Liberty Hgts Date signed Feb 18 46

VS 150

G37562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G37562 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days Hosp.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs Hosp.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Domenica Caprarola

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or ~~wife~~ Liborio Caprarola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 19, 1874

8. AGE: Years 72 | Months 0 | Days 25 | If less than one day 27 hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Luigi Pietrantonio
13. Birthplace Italy

MOTHER
14. Maiden Name Pallini
15. Birthplace Italy

16 (a) Informant Husband
(b) Address 737 N. Milton Ave.,

17 (a) Burial (b) Date thereof 2/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery.
Location North Ave & Rose St.

18 (a) Funeral director Charles E. Schmunck
(b) Address 2001-05 E. Madison St.

19 (a) FEB 18 1946 by Esther E. Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1946 at 11:23 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1946, to 2-15 1946, and that I last saw her alive on 2-15 1946.

Immediate cause of death	Duration
PERITONITIS	
Due to	
Due to	
Other Conditions Cholecystitis, Chronic Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation 2-12-46

Major findings of operation: Chron Cholecystitis, Cholelithiasis; gallstone in gallbladder

of autopsy: Autopsy not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Reese Jr. M.D.
Address Church Home & Hosp. Date signed 2-17-46

VS 150

X Littlefield

637563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

637563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 E 41st St
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 E 41st St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Caroline Kerr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 11 1865

8. AGE: Years	Months	Days	If less than one day
80	8	4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business

FATHER
12. Name John Kerr
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna Marie Hamelton
15. Birthplace Baltimore Md

16 (a) Informant Mary C. Thompson
(b) Address 519 E 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John G. Mosau
(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1946, at 5:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1946, to 2/15 1946, and that I last saw him alive on 2/15 1946;

Immediate cause of death	Duration
Myocardial insufficiency.	10 days.
Due to Lobar pneumonia left lower lobe.	1 wk.
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Compton
Address 3963 Greenmount Ave. Date signed 2/18/46

FEB 18 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 637564

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6805 Dogwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie G. Strong — Elsie G. Strong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hughy F. Strong

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) June 8, 1906

8. AGE: Years 39 | Months 8 | Days 8 9 | If less than one day ....hr. ....min.

9. Birthplace Woodlawn, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Benjamin Meekins
13. Birthplace Woodlawn, Md.

MOTHER
14. Maiden Name Agnes Glick
15. Birthplace Woodlawn, Md.

16 (a) Informant Mr. Hughy F. Strong
(b) Address 6805 Dogwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Hampstown, Md.

18 (a) Funeral director Ellis Funeral
(b) Address 2610 Liberty Heights Ave.

19 (a) Date received by local registrar FEB 18 1946 (b) Filing No. 8 Purington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1946, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1946 to 2/17 1946 and that I last saw her alive on 2/17 1946

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Rheumatic Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Jud. Gen. Hospital Date signed 2/17/46

VS 150

107

CUTLIP

G37565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G37565

write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 S. Hanover st.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME David Franklin Cutlip

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War - II	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Virginia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Mill Creek, W. Va
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name A. W. Cutlip
13. Birthplace Mill Creek W. Va

MOTHER
14. Maiden Name Adie Britt
15. Birthplace Mill Creek, W. Va

16 (a) Informant Mary V. Cutlip
(b) Address 917 Hanover st

17 (a) 19 Feb Burial (b) Date thereof 19-Feb-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location.....

18 (a) Funeral director A. Lee Odell
(b) Address 4644 York Rd.

19 FEB 18 1946 [illegible] Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CUSE OF DEATH Fatty liver
Cerebral Edema
Due to Marked pulmonary congestion.

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?.....
(d) Means of injury.....

23. Signature Benedict Skintarelic M.D.
Medical Examiner.
Date signed 2-15-46

G37566 ✓ G37566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Dunn

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	13	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Watchman at
11. Industry or business Western Md R.R. Machine Sh

FATHER
12. Name Peter F. Dunn
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Katherine Kelly
15. Birthplace Ireland

16 (a) Informant Mr. Bernard E. Dunn
(b) Address 4618 Harcourt Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Beldir Road

18 (a) Funeral director Edgar W. Coppelman's Son
(b) Address 924 E. Eager St.

19 (a) 1946 (Date rec'd by registrar) (b) Ft. Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1946, at 4:32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1945 to Feb. 15 1946 and that I last saw him alive on Feb. 14 1946

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richter M. D.
Address 1706 N. Washington St Date signed 2/16/46

X

G37567

BALTIMORE CITY HEALTH DEPARTMENT ✓ G37567

CERTIFICATE OF DEATH 94a

Registered No.

Please answer all questions in full. Space must be filled in answering each question. If none, or not applicable, write NONE. If unknown, or approximate, state so. Data regarding deceased person should be obtained from most reliable source (preferably from person having knowledge of facts). Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Valley St
(c) Hospital or institution:

10-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Jane Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1863

8. AGE: Years 82 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired school
11. Industry or business Teacher Balto City.

FATHER
12. Name Octavius J. Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie McWilliams
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Howard E. Smith
(b) Address 1635 E. North Ave

17 (a) Burial (b) Date thereof 2-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount Ave & Hoffman St

18 (a) Funeral director Edgar W. Combs & Son
(b) Address 924 E. Eager St.

FEB 18 1946

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Feby 1946, at 1 37 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelfrick M.D.
Medical Examiner
Date signed 18 Feby 46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637568 BALTIMORE CITY HEALTH DEPARTMENT ✓ 637568

CERTIFICATE OF DEATH 8212

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6628 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Koenig, Frank William

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-2813

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Mar.

6 (b) Name of husband or wife Anna Koenig
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 3, 1889

8. AGE: Years	Months	Days	If less than one day
56	7	14	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafarer

FATHER
12. Name ? George Koenig
13. Birthplace ? ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace Baltimore, Md.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Signature of Registrar

FEB 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1946, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1946 to Feb. 17 1946 and that I last saw him alive on Feb. 17 1946.

	Duration
Immediate cause of death Thrombosis in brain; right hemiplegia	3 wks
Due to Cerebral arteriosclerosis	Unknown
Due to	
Other Conditions Arteriosclerosis general	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Jr. Surgeon M. D.
Address Clinical Director Date signed 2/18/46

8

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G37569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Parkwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Cecelia M. Dingley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Benjamin F. Dingley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1872

8. AGE: Years	Months	Days	If less than one day
73	11	2	hr. min.

9. Birthplace Cohoes, N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Fred Ballanger
13. Birthplace Canada

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Robert Dingley
(b) Address 2907 Parkwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Md

18 (a) Funeral director George A Farley
(b) Address Fulton and Fayette

FEB 18 1946 (a) (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1946, at 1.45 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1945, to Feb 16 1946, and that I last saw her alive on Feb 15 1946.

Immediate cause of death	Duration
adenocarcinoma of the rectum	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. H. Cutterman M. D.
Address 2324 Reisterstown Rd Date signed 2/18/46

Treating for Malignancy MR

X

G37570

BALTIMORE CITY HEALTH DEPARTMENT ✓ G37570

CERTIFICATE OF DEATH 137a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. V8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17d.
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto-7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Milford Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** ROBERT E. SHAFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Abraham Shoff
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Myrven Shoff
(b) Address 3011 Milford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cemetery
Location Jefferson Md.

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.

19 (a) FEB 18 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 2-17 1946, at 12 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-30 1946, to 2-17 1946, and that I last saw him alive on 2-17 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Cardiac decompensation	
Due to Coronary thrombosis	
Other Conditions Benign Prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Shuham M. D.

Address Mercy Hosp. Date signed 2-17-46

94a

VS 150

637571 BALTIMORE CITY HEALTH DEPARTMENT 637571
CERTIFICATE OF DEATH
183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East 23rd Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Kursa

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1923

8. AGE: Years	Months	Days	If less than one day
23	10	22	hr. min.

9. Birthplace Nyc York City
(Town, county, and state)
10. Usual Occupation Engineer Medical Corps
11. Industry or business U.S. Army Base Hosp

FATHER
12. Name Michael Kursa
13. Birthplace New York

MOTHER
14. Maiden Name Mary Kozdak
15. Birthplace

16 (a) Informant Mary Kursa
(b) Address Brooklyn New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Holly Cemetery Brooklyn
Location Brooklyn New York

18 (a) Funeral director Wenglish Funeral Home
(b) Address 312 E. Fayette St

19 (a) Harrington Williams Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1946, at 5:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Accident Coast Guard
(a) Date of injury Feb 15 1946
(b) Where did injury occur? 149 E 23rd St Manhattan Lieut Cantor N.Y.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Drowning

23. Signature Benedict Shitarchic M.D.
Medical Examiner.
Date signed 2-16-46

B 1 VS 151

G37572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G37572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3805 Egerton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Springdale ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis M. Silberstein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Late Marie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5. 1895

8. AGE: Years 50 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Boston Mass (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Morris Silberstein
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie Mesnick
15. Birthplace Russia

16 (a) Informant Samuel M. Silberstein
(b) Address 3706 Egerton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19/46 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1946 at 12 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946 to Feb 18 1946, and that I last saw h[illegible] alive on Feb 17th 1946

Immediate cause of death	Duration
Spontaneous Gastric Hemorrhage	1 hr
Due to Ulcer of Stomach	1 yr (?)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael A. Abrams M. D.

Address 1870 Eutaw Place Date signed Feb 19 46

Abrams

637573 [redacted] 32573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 637573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 659 Light St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 659 Light St. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME John a. Clough

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 14th 1945

8. AGE: Years	Months	Days	If less than one day
	3	3	hr. min.

9. Birthplace Bethesda Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Willard Johnson
13. Birthplace Wis.

MOTHER
14. Maiden Name Elizabeth Fox
15. Birthplace Dickerson Md.

16 (a) Informant Mrs. Elizabeth Clough
(b) Address 659 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 19 1946 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17th 1946, at 12 30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Terminal aspiration of
Due to stomach contents.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shitarelic M.D.
Medical Examiner.
Date signed 2-18-46

VS 151

Please write in ink. Space is especially important. Physicians: please write the causes of death clearly and legibly.

G37574 — 74 ✓ — G37574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1129 Holland St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Hollins St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Florence Strevig Shipley

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas Strevig Shipley
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68			..... hr. ..... min.

9. Birthplace ..... (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name John Thomas Strevig
13. Birthplace Westminster Md

MOTHER
14. Maiden Name Ella Brown
15. Birthplace Md

16 (a) Informant Gilbert Gingrich
(b) Address 1104 N Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Kreidler
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) FEB 19 1946 Huntington for Williams Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1946, at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 19 43 to Feb 17 19 46, and that I last saw her alive on Feb 15 19 46

Immediate cause of death ..... Duration

Chronic Myocarditis 5 yrs

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Edmund A Jorgen M. D.
Address 1216 N Howard St (Date signed) Feb 18 46

G37575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G37575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elbridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Sharp

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-5047

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Brown B. Sharp, Jr.
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) April 11, 1921

8. AGE: Years	Months	Days	If less than one day
24	10	6	..... hr. ..... min.

9. Birthplace Elbridge Howard Co. Md.
(Town, county, and state)
10. Usual Occupation Logan Manufacturing Co.
11. Industry or business machine shop.

FATHER
12. Name Charles B. Sappington
13. Birthplace A. A. Co.

MOTHER
14. Maiden Name Ida A. Marshall
15. Birthplace Va.

16 (a) Informant Mrs Ida A. Carter
(b) Address 1927 Fremont ave Elbridge Md

17 (a) Burial (b) Date thereof Feb 19, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Melville Cemetery
Location Elbridge Md.

18 (a) Funeral director S. Lester Karpe
(b) Address 503 Main St, Elbridge Md.

FEB 19 1946 (Huntington Williamsville Md.)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946, at 8:50 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound Fracture of Pelvis. Rupture of kidney, Rupture of right kidney.
Due to multiple tears of Mesentery
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-16-46 at 3:45 A. M.
(b) Where did injury occur? Route #1 – Elbridge Howard Co.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? NO
(d) Means of injury auto & auto collision

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 17 1946

VS 151

X

G37576 GRAGG ✓ G37576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 E. 22 4st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Grogg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26-96.

8. AGE: Years 49 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Ky.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Johns Hopkins Hosp.

FATHER
12. Name Edgar Grogg.
13. Birthplace Ky.

MOTHER
14. Maiden Name Wauda Lee Wheeley
15. Birthplace Ky.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 19 1946 (month) (day) (year)

(c) Cemetery or crematory
Location Lexington Ky.

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address McCulloh & Eachard Sts.

19 (a) FEB 19 1946 (Date rec'd by Registrar) (b) Waiting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1946, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1945 to 2-18 1946 and that I last saw her alive on 2-18 1946

Immediate cause of death Respiratory failure — Duration

Due to Uremia

Due to Papillary adenocarcinoma of rt. Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-10-46

Major findings of operation: Widespread metastatic carcinoma

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard T. Knight M.D.

Address Johns Hopkins Hosp. Date signed 2-19-46

G37577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G37577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2822 Winchester St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Winchester St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine W. Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William E. Jenkins
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) March 27, 1867

8. AGE: Years	Months	Days	If less than one day
78	10	21	..... hr. ..... min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William H. Rice
13. Birthplace Del.

MOTHER
14. Maiden Name Mary E. Carpenter
15. Birthplace Del.

16 (a) Informant Mr. Wm. E. Jenkins
(b) Address 2822 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Meadow Ridge
Location Washington Blvd.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1946 at 1.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1946 to Feb 17 1946 and that I last saw h[illegible] alive on Feb 16 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension cardio vascular disease	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert F. Kellerman M. D.
Address 6 E. Biddle St. Date signed

VS 150

X

G37578 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 332

G37578

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1841 N. Collington Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Hill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Roland Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1860

8. AGE: Years	Months	Days	If less than one day
85	8	12	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Alfred Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Bogg
15. Birthplace Va.

16 (a) Informant Virginia Shockey
(b) Address 3233 Lindale Ave.

17 (a) Burial (b) Date thereof 2/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Downing
Location Oak Hall, Va.

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 FEB 19 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946, at 1120P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 15 1945 to February 16 1946, and that I last saw her alive on Feb 16 1946.

	Duration
Immediate cause of death Myocardial Insufficiency and Cardiac Dilatation	2 Days
Due to Influenza and Lobar Pneumonia	15 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg M. D.
Address 2025 E. North Ave. Date signed

VS 150

G37579 [redacted] Busick ✓ G37579 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2720 Harlem Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Lillian (Lilian) Busick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1877

8. AGE: Years 68 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Samuel J. Busick
13. Birthplace Kent County, Md.

MOTHER
14. Maiden Name Anna M. Kelly
15. Birthplace Md.

16 (a) Informant Lilian S. Busick (deceased)
(b) Address 2720 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/46 (month) (day) (year)
(c) Cemetery or crematory Still Pond
Location Still Pond, Kent County, Md.

18 (a) Funeral director John O. Mitchell's Sons, Inc.
(b) Address 1900 Eutaw Place

19 FEB 19 1946 (Date received by registrar) [illegible] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1946, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Feb 17 1946, and that I last saw h[illegible] alive on Feb 17 1946

Immediate cause of death Cardiac Vas Cerebral hemorr | Duration 3 [illegible]
Due to Hypertension Stroke for 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.
Address 62 N 40 St Date signed

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37580 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G37580 [redacted]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mencke

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm Mencke

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Dec 10 1878

8. AGE: Years 67 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Alonzo Evans
13. Birthplace Baltimore

MOTHER
14. Maiden Name Charlotte Warner
15. Birthplace Baltimore

16 (a) Informant Wm Mencke
(b) Address 2429 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

FEB 19 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1946, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1946, to 2/18 1946, and that I last saw h[illegible] alive on 2/18 1946.

Immediate cause of death Toxemia — Duration 5 days

Due to Peritonitis — 5 days

Due to Multiple diverticulitis with rupture — One week

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Chenin M.D.
Address Sinai Hospital Date signed 2/18/46

VS 150

X

637551

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 637581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 W. Montgomery
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 W. Montgomery
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ward

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Iris Hill
(b) Address 505 Burn Way Towson Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) FEB 19 1946 (Date rec'd by registrar) Registration for Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/1946, at 7 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 15 1946 to Feb 14 1946 and that I last saw h[illegible] alive on Feb. 14, 1946

Immediate cause of death: Chronic Valvular Heart Disease — Duration: Final Month

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Timothy Shelton
Address 908 S. Sharp St Date signed 2/16/46

VS 150

I CHARGE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37582 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 A

Registered No. G37582

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Druid Hill Ave.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MARY DUTTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1886

8. AGE: Years 59 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Benjamin Duttod
13. Birthplace Finksburg, Md.

MOTHER
14. Maiden Name Jennie Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Ellen D. Brooks
(b) Address 2107 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) [signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1946 to 2-15 1946, and that I last saw her alive on 2-14 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V V Butler

Address 1823 Druid Hill Ave. Date signed Feb 19 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G37583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Division
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 M

(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Barclay St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Joseph Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	married

6 (b) Name of husband or wife Olympia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1881

8. AGE: Years	Months	Days	If less than one day
64	11		hr. min.

9. Birthplace New Orleans, La.
(Town, county, and state)

10. Usual Occupation Gardner

11. Industry or business

FATHER
12. Name Joseph Conway
13. Birthplace New Orleans, La.

MOTHER
14. Maiden Name Emily Dourley
15. Birthplace New Orleans, La.

16 (a) Informant Evelyn Blank
(b) Address 3110 Barclay St

17 (a) Burial (b) Date thereof 2-21-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Holland
(b) Address 1691 Druid Hill Ave

19 (d) FEB 19 1946 Thurlington Williams, M.D.
(Date Rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17- 1946 at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14- 1946 to 2-17- 1946, and that I last saw h[illegible] alive on 2-17- 1946.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	4 days
Due to Hypertensive Cardio-vascular	
Due to Renal	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thurlington Williams M. D.
Address 1111 Madison Ave Date signed 2/18/46

G37584 [redacted] G37584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. [redacted]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Duffy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Michael Duffy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11-1869

8. AGE: Years 76 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F. Malia
13. Birthplace Ireland

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Michael Duffy
(b) Address 1519 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946, at 5:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1945 to 2-16 1946, and that I last saw her alive on 2-16 1946

Immediate cause of death Cerebral Hemorrhage — Duration 3 Days.
Due to Arteriosclerosis — 5 yr.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature [redacted]
Address 707 Fort Ave Date signed 2-16-46 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

637585 Registered No. 637585

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 E. 31st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. 31st St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Meid Gerlach

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband/wife John A. Gerlach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4th 1866

8. AGE: Years	Months	Days	If less than one day
79	5	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Conrad Meid
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Schmick
15. Birthplace Balto. Md.

16 (a) Informant John A. Gerlach
(b) Address 1602 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) Date rec'd by local registrar FEB 19 1946 (b) Printing for Williams Mfg Co Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18th 1946, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 18 1946 and that I last saw h. alive on Feb 18 1946

Immediate cause of death	Duration
Cardiac Insufficiency	
Due to Chr Arthritis	
Due to Chr Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C. Mennuger M. D.
Address 800 E North Ave Date signed 2/19/46

VS 150

G37586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B Registered No. G37586

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Lang

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-7595

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minnie Lang

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28-1893

8. AGE: Years 52 (53) | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name Christian Lang
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name
15. Birthplace Balto. Md.

16 (a) Informant Minnie Lang
(b) Address 2407 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19/46 (month) (day) (year)
(c) Cemetery or crematory Immanuel Cem.
Location Grindon Lane.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) FEB 19 1946 (Date rec'd by Registrar) (b) Wm. J. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1946 at 7 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1946 to Feb. 15 1946, and that I last saw him alive on Feb. 15 1946.

	Duration
Immediate cause of death Cerebral abscess	
Due to	
Due to Ruptured abscess temporal (Brain tumor)	4 wks
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 15 1946
Major findings of operation: Ruptured abscess temporal
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. H. Richardson M. D.
Address University Hosp. Date signed 2/15/46

Balto. 1, Md. X

VS 150

G37587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G37587

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Main Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Main Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter S. Whitman

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lucille N. Whitman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1890

8. AGE: Years	Months	Days	If less than one day
56	1	8	hr. min.

9. Birthplace Wilkes Barre, Pa.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Mutual Ben. Health Acc. Asso.

FATHER
12. Name Harry E. Whitman
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Sweitzer
15. Birthplace Pa.

16 (a) Informant Mrs. Lucille Whitman
(b) Address 210 E. 38th St., N. Y., N. Y.

17 (a) Removal (b) Date thereof 2/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mission Cem.
Location San Antonio, Texas

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 FEB 19 1946 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946, at 3 45 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion
right
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Feb. 19 1946

G37588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G37588

Please write the causes of death clearly and legibly. Physician: please write the causes of death clearly and legibly. Use accompanying supplement.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Mt Olivet Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 6 Mt. Olivet Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Concetta M. Di Fatta

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Salvatore

6 (c) If alive, give age 4 years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1917

8. AGE: Years	Months	Days	If less than one day
28	5/5	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Tire Bros Store

FATHER
12. Name Joseph Sirio.
13. Birthplace Baltimore.

MOTHER
14. Maiden Name Carolina Carullo
15. Birthplace Italy

16 (a) Informant Mr Joseph Sirio
(b) Address 6 N. Mt Olivet Lane

17 (a) Burial, cremation, or removal (b) Date thereof 2/21/46
(Month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem
Location 4430 Belair Road

18 (a) Funeral director John Cowan & Son
(b) Address 901-03 Gallows St

19 (a) (Date received by Registrar) (b) Registrar

FEB 19 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17th 1946 at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to result of mental depression

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-17-46 at P.
(b) Where did injury occur? 6 Mt. Olivet Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? n/a
(d) Means of injury Burners on kitchen range

23. Signature Benedict Skolaris M.D.
Medical Examiner.
Date signed 2-18-46

G37589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15-9

Registered No. G37589

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4600 Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Fleet St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Cakowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18 1946

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Cakowski
13. Birthplace Poland

MOTHER
14. Maiden Name Blanche Mudrack
15. Birthplace Fayette county Penna.

16 (a) Informant Eugene Cakowski
(b) Address 2214 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 404 S. Chester Street

19 (a) FEB 19 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1946 at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Feb 1946 to 18 Feb 1946 and that I last saw h.r alive on 17 Feb 1946

Immediate cause of death	Duration
Cardiac Respiratory Failure	
Due to Atelectasis Pulmonary Acute	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address St Joseph's Hosp Date signed 2/19/46 M.D.

VS 150

637590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 637590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Brentwood ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wilton Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-1895

8. AGE: Years 50 | Months 6 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Caroline Co, Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Walker Lewis
13. Birthplace Va.

MOTHER
14. Maiden Name Sheila Lewis
15. Birthplace Va.

16 (a) Informant Lillian Nixon
(b) Address 3112 Brentwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Am.
Location A.A. County, Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1297 N. Carolina St

19 (d) FEB 19 1946 Huntington Williams Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1946 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1946 to 2-16 1946 and that I last saw him alive on 2-6 1946.

Immediate cause of death	Duration
(a) Intracranial Hemorrhage	
Due to (b) Hypertensive Cardiovascular renal disease	
Due to (c) Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1227 N. Carolina Date signed 2-19-46

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registration No. 637591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution:
Hospital for Women of Md. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 Clipper Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Maude Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband ~~or wife~~ Charles Bennet Johnson
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) JANUARY 3, 1896

8. AGE: Years	Months	Days	If less than one day
50	1	15	..... hr. ..... min.

9. Birthplace Shenandoah, Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Douglas
13. Birthplace Shenandoah, Va.

MOTHER
14. Maiden Name Lillian Taylor
15. Birthplace Shenandoah, Va.

16 (a) Informant Mary Bowman (daughter)
(b) Address 1335 Clipper Hgts. Ave.

17 (a) Burial (b) Date thereof Feb 21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ St. Mary's
Location Hampstead

18 (a) Funeral director Edward F. Bowman
(b) Address 3615 Eastern Ave

FEB 19 1946 (b) Huntington Williams, M.D.
(Date rec'd by Reg.) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 18 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1946, to Feb. 18 1946, and that I last saw her alive on Feb. 18 1946

Immediate cause of death	Duration
Hypertension Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions Anaemia, Hypertension, Hydropericardium	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arch V. Gambrill M. D.
Address Hosp. for Women of Md. Date signed 2/18/46

X

G37592 Single
642 Wash Blvd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1830

G37592
Registered No.

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 Baldwin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1521 Baldwin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry R. Mason.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth J. Mason
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March 24, 1868

8. AGE: Years	Months	Days	If less than one day
77	10	24	hr. min.

9. Birthplace Maryland
(State or foreign country, and city)
10. Usual Occupation Retired
11. Industry or business Laborer.

FATHER
12. Name Jonathon Mason
13. Birthplace Maryland.

MOTHER
14. Maiden Name Margaret Hopkins
15. Birthplace Maryland

16 (a) Informant Elizabeth J. Mason.
(b) Address 1521 Baldwin St.

17 (a) Burial (b) Date thereof Feb 20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Emanuel
Location Howard Co Md.

18 (a) Funeral director Edmonds & Donovan
(b) Address 3615-17 Eden St Balto

19 (a) FEB 19 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946, at 11 20/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Feb 17 1946 and that I last saw him alive on 2-17-46 19

Immediate cause of death	Duration
Bronchopneumonia - Arteriosclerosis	
Due to Encephalomalacia	4 yr.
Due to Arteriosclerosis - Mental	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 642 Wash Blvd Date signed 2-19-46

X

G37593 170129

G37593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 133a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Abbott Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia L. McCafferty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wetherington P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-20

8. AGE: Years 25 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER — 12. Name Harrison Pearce
13. Birthplace Md.

MOTHER — 14. Maiden Name Lula Emy
15. Birthplace Md.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave

19 (a) FEB 19 1946 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1945 to Feb. 17 1946 and that I last saw h[er] alive on Feb. 17 1946

Immediate cause of death Respiratory failure — Duration

Due to Nephritis

Due to Renal failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Strauch M. D.

Address Johns Hopkins Hosp. Date signed 2-17-46

VS 150

637594

487690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

637594 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WHITE PANEL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Schwarts Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Garrett.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-76

8. AGE: Years	Months	Days	If less than one day
69.	7	3	hr. min.

9. Birthplace D.C. (Town, county, and state)
10. Usual Occupation Home work.
11. Industry or business

FATHER
12. Name Edward Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Melvina Garland
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest Cem
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Hemsley for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1946 at 2. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1946, to Feb. 16 1946, and that I last saw her alive on Feb. 16 1946.

Immediate cause of death	Duration
Peritonitis	
Due to Carcinoma of colon	
Due to	
Other Conditions Metastases to liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Grant Taylor M. D.
Address Johns Hopkins Hospital Date signed 2/18/46

VS 150

637595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

637595 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Warner Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Pinnell Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Jerome Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1891

8. AGE: Years	Months	Days	If less than one day
54	11	9	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace N C.

MOTHER
14. Maiden Name Julia Wright
15. Birthplace N. C.

16 (a) Informant Mr. Jerome Williams
(b) Address 609 Warner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk, Virginia

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946, at 8:15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions Acute Alcoholism
Fatty degeneration of liver marked
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 21/2

(a) Date of injury Feb. 12 1946 1 P.M.
(b) Where did injury occur? 1350 Cleveland St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall down stairs

23. Signature Robert C. Graham M.D. (Medical Examiner.)
Date signed Feb. 18 1946

G37596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G37596

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 840 Edmondson ave

(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)

(d) Street No. 840 Edmondson ave — (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mamie McGill —

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louis McGill

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Feb - 2 - 1900

8. AGE: Years: 46 | Months: — | Days: 15 | If less than one day: hr. min.

9. Birthplace: Lynchburg S.C. — (Town, county, and state)

10. Usual Occupation: Nurse —

11. Industry or business

FATHER

12. Name: Fortune Jefferson

13. Birthplace: Lynchburg S.C.

MOTHER

14. Maiden Name: Rosa Thomas

15. Birthplace: Lynchburg — S.C. —

16 (a) Informant: Estrella Pickens

(b) Address: 840 Edmondson —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 20, 1946 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Mem. Park

Location

18 (a) Funeral director: Mrs Katie R Williams

(b) Address: 322 N. Schroeder St

19 (a) FEB 19 1946 (Date filed by Registrar) (b) Funeral for Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/17 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 2/17 1946, and that I last saw h[illegible] alive on 2/15 1946.

	Duration
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Hypertension	
Due to: arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: David Swanson M. D.

Address: 172 W Lee Date signed: 2/18/46

X

G37597
JL - 19165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1936

G37597
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 - 1 - 14
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wyatt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10. 1893

8. AGE: Years	Months	Days	If less than one day
53	1	6	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER
12. Name Thomas Robinson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ellen
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Feb. 20-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3224 W Lombard St.

19 (a) (b)
(Date rec'd by registrar)
Printing for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1946 at 7.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1936 to Feb. 16 1946 and that I last saw h er alive on Feb. 16 1946

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to	
Due to	
Other Conditions ASHD	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret McDavis
Address B C H Date signed 2-17-46

FEB 19 1946
(Date rec'd by registrar)

G37598

JL - 99001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G37598

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Henry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
63 ?	?	?	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1946 at 8.09 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1946 to Feb. 16 1946 and that I last saw h[illegible] alive on Feb. 16 1946

Immediate cause of death	Duration
Bronchopneumonia	
Due to Cerebral hem. acc.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M Downs M. D.
Address B. C. H. Date signed 2-17-46

VS 150

X

G37599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

EB # 85274

Registered No. 1226 G37599

The following items of information should be carefully supplied. Every item must be answered, with UNFADING INK. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 11
(e) Length of stay in Baltimore (yrs., mos., or days) 81 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Bruns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Anthony Bruns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1865

8. AGE: Years	Months	Days	If less than one day
81	1	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Wesley Sunderland
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Elizabeth Marine
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Dunderdale

FEB 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 18, 1946, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1945 to Feb. 18, 1946 and that I last saw her alive on Feb. 18, 1946

Immediate cause of death	Duration
Peritonitis	2 days
Due to Perforation of ileum	2 days?
Due to Acute intestinal obstruction	6 days?
Other Conditions Hypertension, Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation —
of autopsy Valvulitis & Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 5, 1943 at M
(c) Where did injury occur? 921 N. Duncan St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Slipped on waxed floor
23. Signature Thomas J. O'Neill M. D.
Address Balto City Hosp Date signed 2-18-46

VS 150

To Be Approved By Medical Examiner. Howard J. Andersen, Asst. M.E.

G37600 G37600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 402 S. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 S. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1904

8. AGE: Years	Months	Days	If less than one day
41	11	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank R. Robinson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Robinson
15. Birthplace Md.

16 (a) Informant Margaret Cook
(b) Address 1507 Eastern

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

FEB 19 1946 (Date rec'd by Registrar) (By) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 19 46 at 12 40 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Glomerulonephritis

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Turbinette M.D.
Medical Examiner.
Date signed 2/17/46

VS 151

Write the causes of death clearly and legibly.

G37601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G37601

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Chisolm (Earl Smith)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1913

8. AGE: Years	Months	Days	If less than one day
32	5	19	hr. min.

9. Birthplace Blackstock, S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Saul Smith
13. Birthplace S.C.

MOTHER
14. Maiden Name Chattie Holley
15. Birthplace S.C.

16 (a) Informant Nancy Stevenson
(b) Address 1850 N. 22nd St. Phila. Pa.

17 (a) Burial (b) Date thereof 2 / 19 / 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Blackstock, S.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 20 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946 at 12 30 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death).

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-16-46 at 12 30 A. M.
(b) Where did injury occur? 217 N. Montford Ave 2nd floor front.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shooting

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 17 1946

X

637602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

637602 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steven Hill (Stephen Hill)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1884

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Susan
15. Birthplace Md.

16 (a) Informant Rosie Scott
(b) Address 540 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pennsylvania Ave

19 FEB 19 1946 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1946, at 11:45 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 17 1946

37603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

G37603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719½ W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clemacie Gotham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	negro	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 19[illegible]

8. AGE: Years	Months	Days	If less than one day
23			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Eldis Copeland
13. Birthplace N.C

MOTHER
14. Maiden Name Sallie Greig
15. Birthplace N.C.

16 (a) Informant Sallie Coepland
(b) Address 719½ W. Saratoga st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1940 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Bentley ave

19 (a) 2 9 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1945, at 9.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1945 to Feb. 17 1945, and that I last saw her alive on Feb. 17 1945.

Immediate cause of death Cerebral Embolism	Duration
Due to Cerebral Embolism	
Due to Brain Tumor	over
Other Conditions Thrombosis (coronary)	

(Include pregnancy within 3 months of death)
Date of operation Feb. 12, 1945
Major findings of operation: Brain Tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address University Hosp. Date signed 2/17/45

Balto. Md. X

correct age is especially important. Physicians: please write the

VS 150

637604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

637604
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4124 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Schafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/46

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto- Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Edward W. Schafer
13. Birthplace Md

MOTHER 14. Maiden Name Rose A. Sandkuhler
15. Birthplace Md

16 (a) Informant Edward W. Schafer
(b) Address 4124 Hamilton Ave

17 (a) Burial (b) Date thereof 2/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Lucke
(b) Address 5305 Harford Road

19 (a) FEB 19 1946 (b) Huntington Williams, M.D.
(Date received by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Feb 1946 at 4 Pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Feb 1946 to 16 Feb 1946 and that I last saw h[illegible] alive on 16 Feb 1946

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Atelectasis Pulm. bilat	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Md. Joseph Hosp Date signed 2/16/46

161a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G37605
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S C (b) County
(c) City or town West Columbia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Axtell Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ora Lee Lindsay

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Swanie Bird Lindsay

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 7-3-85

8. AGE: Years 60 | Months 7 | Days 15 | If less than one day: hr. min.

9. Birthplace Michigan
(State or foreign country, and state)

10. Usual Occupation Hobby Shop.

11. Industry or business

FATHER
12. Name Ora E. W. Lindsay
13. Birthplace Mich

MOTHER
14. Maiden Name Alma Paddie
15. Birthplace Michigan

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 2/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location West Columbia, S. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(c) FEB 19 1946 (d) Frederick Fox Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1946, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1946 to Feb 18 1946 and that I last saw living on Feb 18 1946.

Immediate cause of death: Subarachnoid hemorrhage x. Arteriosclerosis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray W. Chambers M.D.
Address Balto. Md. Date signed 2/18/46

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G37606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Wilcox St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Wilcox St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Malcolm
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Apr 28, 1864
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 81 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Berney
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Wall
15. Birthplace Md.

16 (a) Informant Mrs. Margt. O'Brien
(b) Address 1212 Wilcox St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) FEB 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1946 at 4.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1946 to Feb 17 1946 and that I last saw h[er] alive on Feb 17 1946

Immediate cause of death Coronary Occlusion — Duration 2/15/46
Due to Chr Myocarditis — Duration 1943
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Rossner
Address 801 N Kenwood Ave Date signed 2/18/46

correct age is especially important. Physicians; please write the

VS 150

G37607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. G37607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ...Jon
(c) Hospital or institution:
John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ...
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1717 E Madison Ave
(If rural give location)
(e) Citizen of foreign country? ...(Yes or No)
If yes, name country ...

3 (a) FULL NAME Dolores Stewart

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife ...
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1935

8. AGE: Years	Months	Days	If less than one day
10 11	3	16 20	... hr. ... min.

9. Birthplace ...
(Town, county, and state)
10. Usual Occupation ...
11. Industry or business ...

FATHER
12. Name Harry Stewart
13. Birthplace Harrisburg, Pa.

MOTHER
14. Maiden Name Edith Price
15. Birthplace Richmond, Va

16 (a) Informant Harry Stewart (father)
(b) Address 1499 E Madison St.

17 (a) Burial (b) Date thereof Feb. 11 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St.

FEB 19 1946 (Date rec'd by registrar) (Huntington Wilson) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1946, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wounds of face and head.
Due to ...
Other Conditions ...
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 10/2
(a) Date of injury 2/17/46 about 8:00 P.M.
(b) Where did injury occur? 1717 E Madison Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Accidentally shot by brother with 22 rifle

23. Signature ... M.D.
Medical Examiner.
Date signed 2/18/46

VS 151

637608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 637608

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S. Light St.
(c) Hospital or institution: Ls Balts. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Sixth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Drager

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Theodore Drager

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/9/1870

8. AGE: Years 75 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Christian Schwab
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Mentz
15. Birthplace Germany

16 (a) Informant Mrs Loretta Florence (Daughter)
(b) Address 3812 Sixth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director A. J. Bozzuto & Evans
(b) Address 1400 S. Charles St

19 (a) Filed (b) Registrar's signature FEB 19 1946 Huntington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1946, at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1946 to 2/18 1946, and that I last saw her alive on 2/18 1946.

Immediate cause of death	Duration
(a) Generalized Carcinomatosis	
Due to (b) Possible ovarian	
Due to (c) malignancy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Whitacre M.D.

Address S.B.G.H. Date signed 2/18/46

1213 S. Light St.

G37609 BALTIMORE CITY HEALTH DEPARTMENT G37609
CERTIFICATE OF DEATH 93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3212 TAylor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Taylor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM G HOFMANN

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary K Hofmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 17 1867

8. AGE: Years 78 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr Frederick Hofmann
(b) Address: 3212 Taylor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Taylor Ave

18 (a) Funeral director: Lanahan Funeral Home
(b) Address: 7401 Belair Road

19 (a) FEB 19 1946 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/46 19..., at 3:[illegible] M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 2/18/46

VS 151

Dr. Sayer

G37610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G37610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2602 Southern Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Southern Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME FREDERICK SCHROTH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Mary Schroth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28, 1892

8. AGE: Years	Months	Days	If less than one day
53	10	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Restaurant
11. Industry or business

FATHER
12. Name George Schroth
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Weigner
15. Birthplace Germany

16 (a) Informant Mrs. Mary Schroth
(b) Address 2602 Southern Avenue

17 (a) Burial (b) Date thereof 2/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location ~~FOREST~~ A.A. Co., Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) FEB 19 1946 (b) Huntington Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1946, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Feb. 18 1946 and that I last saw h/m alive on Feb. 18 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer M.D.
Address 4808 Harford Rd. Date signed 2/18/46

VS 3

G37611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. G37611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 236 E. Montgomery St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 E. Montgomery St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander J. Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No. 99-09-4587

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Benson

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
abt. 50			hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Mfg Boxboard

FATHER
12. Name Alex Armstrong
13. Birthplace Scotland

MOTHER
14. Maiden Name Agnes Thuston
15. Birthplace Scotland

16 (a) Informant Mrs Alex J Armstrong
(b) Address 236 E Montgomery

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-19-46 (month) (day) (year)

(c) Cemetery or crematory Mariedale Pa

Location

18 (a) Funeral director J. J. Tobey Sons
(b) Address 218 Light St.

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Huntingtown, Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18- 1946, at 8:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Anthracosis, marked.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutare Lab M.D.
Medical Examiner.
Date signed 2-19-46

G37612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G37612

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Elliott Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Elliott Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William C. League

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-4340

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9, 1896

8. AGE: Years 49 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Nelson League
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Theresa Hill
15. Birthplace Balto. Md

16 (a) Informant Mrs. Theresa Pajkin
(b) Address 3016 Elliott Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/ (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

19 (a) Date received FEB 19 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1945 to Feb 16 1946 and that I last saw h[illegible] alive on Feb 7 1946.

	Duration
Immediate cause of death: Myocardial Failure, Acute	1 hr.
Due to: Rheumatic Heart Disease	40 yrs.
Due to:	
Other Conditions: Carcinoma of Rectum	1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeGroup M.D.
Address 601 S. Ellwood Ave. Date signed 2/18/46

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37613 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 S.CHAPEL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S.CHAPEL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY P.SLITZER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: CHARLES SLITZER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV.25 1871

8. AGE: Years 74 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name ROBERT POWELL
13. Birthplace BALTO.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO.

16 (a) Informant CHARLES T.SLITZER (SON)
(b) Address 505 S.CHAPEL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB.20/46 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lally & Zeiler Inc.
(b) Address 403 S.WOLFE ST.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB.16 1946 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1945 to Feb. 16 1946 and that I last saw h.e alive on Feb. 16 1946.

Immediate cause of death: Myocardial Insufficiency — Duration 3 days
Due to Chronic Myocarditis — 6 mos
Due to Hypertension — about 6 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John V. Englebrecht M. D.
Address 1802 Eastern Ave Date signed 2-18-46

VS 150

correct age is especially important. Physicians: please write the

G37614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

Registered No. G37614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 S. Caulkling St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 S. Caulkling St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Walter M. Jones

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ALETHEA JONES

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCT. 17 1892

8. AGE: Years	Months	Days	If less than one day
53	4	1	..... hr. ..... min.

9. Birthplace RALIEGH N.C.
(Town, county, and state)

10. Usual Occupation AUTO. MECHANIC

11. Industry or business WEISS MOTOR CO.

FATHER
12. Name FLOYD JONES
13. Birthplace N.C.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace N.C.

16 (a) Informant ROBERT JONES (SON)
(b) Address 428 HORNELL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 21/46 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly K Zeiler Inc
(b) Address 403 S. WOLFE ST.

19 (a) FEB 18 1946 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-1946 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Benedict Skotarski M.D.
Medical Examiner.
Date signed 2-19-46

637615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. 637615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 McCulloh (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Leroy Kirk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1924

8. AGE: Years	Months	Days	If less than one day
22		11	hr. min.

9. Birthplace Ayden, N. C. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Elbert Kirk
13. Birthplace Ayden N. C.

MOTHER
14. Maiden Name Fannie Williams
15. Birthplace Ayden, N. C.

16 (a) Informant Fannie Kirk
(b) Address 1527 McCulloh St

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/19/46 (month) (day) (year)
(c) Cemetery or crematory Rocky Mount, N. C.
Location

18 (a) Funeral director Chas H. Alexander
(b) Address 12 cor. McCulloh St

(c) (b)
(Date received by Registrar) (Registrar)

FEB 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Feb 1946 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Feb 1946 to 15 Feb 1946 and that I last saw him alive on 12 Feb 1946

Immediate cause of death Anesthesia – Na Pentothal — Duration 45 min

Due to

Due to

Other Conditions Pseudo-hypertrophic muscular dystrophy

(Include pregnancy within 3 months of death)

Date of operation 15 Feb 46

Major findings of operation:

of autopsy: Massive Pulm. atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence February 15 at 1946 M
(c) Where did injury occur? Tarboro (City or town) Edgecombe (County) N.C. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury Dr. Dees ran anesthesia

23. Signature Edwin O Dees, Jr. M. D.
Address Univ. Hosp. Date signed 2/15/46

Howard & Wolcott, M.D.'s

Huntington Williams Registrar

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

637616 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5301 Wayne Ave.,
(c) Hospital or institution:

28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Wayne Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Elizabeth Scallen

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John W. Scallen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1861

8. AGE: Years	Months	Days	If less than one day
84	3	10	hr. min.

9. Birthplace New York City, N. Y.
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name David Kohler
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Ann Brown
15. Birthplace England

16 (a) Informant Nan Elizabeth Eberman
(b) Address 5301 Wayne Ave.,

17 (a) Burial (b) Date thereof Feb 20-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Blvd

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) FEB 19 1946 (Date received by Registrar) (b) Huntington Williams, Registrar

VS 3

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Feb. 18th 1946, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Feb 18 1946. and that I last saw h[illegible] alive on Feb. 18 1946.

Immediate cause of death (a) Cerebral Hemorrhage — Duration 10 minutes
Due to
Due to
Other Conditions Arterio-Sclerosis — 5 yrs.?
Heart Disease
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers
Address 4105 Liberty Hts. Date signed 2/11/46
M. D.

X

G37617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1772

G37617 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 N. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Behovith Williams (Behorieftle)

3 (b) If veteran, name war None

3 (c) Social Security Account No. 214-16-6240

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1895

8. AGE: Years 50 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Chauffeur.

11. Industry or business (Employed)

FATHER
12. Name George Williams
13. Birthplace Saint Constantine Ala.

MOTHER
14. Maiden Name Malvina Hart.
15. Birthplace Saint Hill Miss.

16 (a) Informant Edna Williams
(b) Address 1519 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Carrollton Ave. Baltimore, Md.

19 1946 (a) (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946, at 4 15 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Delirium Tremens.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Feb. 17 1946

G37618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Copy ✓108

G37618 Registered No. 4747

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Ashland Ave
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore, M
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Ashland Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas Johnson ✓

3 (b) If veteran, name war -

3 (c) Social Security Account No. - -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
60	-	-	hr. min.

9. Birthplace Anne Arundel Co Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Johnson
13. Birthplace Anne Arundel Co

MOTHER
14. Maiden Name Josephine —
15. Birthplace Anne Arundel Co.

16 (a) Informant Ida Howard
(b) Address 1205 Ashland Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 19 1946 (Date rec'd by registrar) Hunter Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946, at 4pm; M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1946 to 1/19 1946 and that I last saw h[illegible] alive on 1/19 1946

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lightston Jr M. D.
Address 501 Cherry Hill Rd. Date signed 1/20/46

F 3307

X

G37619

CWK-90778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G37619

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2- 20-
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colo

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8-1880

8. AGE: Years 65 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Curtis Fletcher
13. Birthplace Maryland

MOTHER
14. Maiden Name Arelia Mattox
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 Filed FEB 19 1946 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1944, to Feb. 11 1946, and that I last saw h im alive on Feb. 11 1946

	Duration
Immediate cause of death: Cardiac failure	
Due to: Lueti heart disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address B.C.H. Date signed 2-14-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3306

X

G37620

TN. 98242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G37620

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the information above as carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife Ella

6 (c) If alive; give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years ? 49 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Montgomery
13. Birthplace Maryland

MOTHER
14. Maiden Name Sara
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Local Johns Hopkins Medical School FEB 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 19 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1946 19 at 2.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2nd 1946 to Feb 10 1946 and that I last saw him alive on Feb 10 1946

Immediate cause of death: pneumonia R.L.L. — Duration

Due to

Due to

Other Conditions A S H D

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M Davis M. D.
Address B.C.H. Date signed 2-14-46

VS 150

3305 X

37621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37621
Registered No.

CWK-98343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1m 8d
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Adam Muzak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24-1885

8. AGE: Years	Months	Days	If less than one day
60	1	17	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Muzak
13. Birthplace Austria

MOTHER
14. Maiden Name Eva ?
15. Birthplace Austria

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 18 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) FEB 19 1946 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1946 to Feb. 11 1946, and that I last saw him alive on Feb. 11 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration: 5

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 2/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3304

637622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

637622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Dreyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/46

8. AGE: Years	Months	Days	If less than one day
1 hr		26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Dreyer
13. Birthplace ?

MOTHER 14. Maiden Name Grace Hebler
15. Birthplace ?

16 (a) Informant Hospital records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 16 1946

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 19 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1946, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946, to Feb 12 1946, and that I last saw h[illegible] alive on Feb 12 1946.

Immediate cause of death	Duration
Resp. Failure	
Due to Acidosis	
Due to Infectious diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard Bowen M. D.
Address [illegible] Dept Date signed 2/12/46

VS 150

F 3308

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

37623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37623 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1/4 days

2. USUAL RESIDENCE OF DEASCED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Pennsylvania Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Borgeas | Baby Boy Borgeas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/8/46
8. AGE: Years | Months | Days | If less than one day: 6 hr. min.
9. Birthplace: University Hospital (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER | FATHER
12. Name: Garland Mayo
13. Birthplace: N. Carolina
14. Maiden Name: Lillian Borgeas
15. Birthplace: Baltimore

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: University Medical School FEB 18 1946

18 (a) Funeral director: Commissioner of Health
(b) Address
FEB 19 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1946 at M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1946 to 2/8 1946 and that I last saw him alive on 2/8 1946.

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to Toxemia of Preg.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. H. Robinson
Address Univ. Hosp. Date signed 2/16 M.D.

VS 150

3309

X

G37624
JL - 99323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G37624 832 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore East
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 13 Box 310- Balto, 21 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John W. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-10-8578

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aprr. 18, 1881

8. AGE: Years	Months	Days	If less than one day
64	9	28	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Riley Cook
13. Birthplace W. Va.

MOTHER
14. Maiden Name Elizabeth Grayley
15. Birthplace W. Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 2-19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hopton W. Virginia
18 (a) Funeral director James L. Brundage
(b) Address 1867 Eastern Ave Rd.
19 Filed 2-20-46 by registrar Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1946, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1946 to Feb. 16 1946, and that I last saw him alive on Feb. 16 1946

Immediate cause of death	Duration
Cerebral vascular Accr.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Margaret M. Davis M. D.
Address B C H Date signed 2-19-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

637625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 a

Registered No. 637625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 192 days
(e) Length of stay in Baltimore (yrs., mos., or days) 192 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Waltham
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 River St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Burke, Charles Leo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1885

8. AGE: Years	Months	Days	If less than one day
61	0	9	hr. min.

9. Birthplace Waltham, Mass.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Seafarer

FATHER
12. Name Thomas Burke
13. Birthplace Ireland

MOTHER
14. Maiden Name Miriah Keough
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 2-22-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvary Cem.
Location Waltham, Mass.

18 (a) Funeral director Keenan & Son.
(b) Address 32 S. Broadway

19 (a) FEB 20 1946 (b) Hunter Williams
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1945 to Feb. 18 1946, and that I last saw him alive on Feb. 18 1946.

Immediate cause of death:	Duration
Respiratory Failure	
Due to Carcinoma of Esophagus	6 months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/28/45

Major findings of operation: Carcinoma of Esophagus

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifford F. Moser

Address U S Marine Hosp Date signed 2/19/46
Balto, Md

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use

637626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

SAFreed X ✓ 55E

637626 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co. Catonsville
(c) City or town Baltimore 23.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Forbush Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Paul Sapp Sr.

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 213-07-3660

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lydia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 23 1881

8. AGE: Years: 64 | Months | Days: 26 5 | If less than one day: hr. min.

9. Birthplace: Sherman N. Y. (Town, county, and state)

10. Usual Occupation: Millwright

11. Industry or business: Fabrication Shop

FATHER
12. Name: William T. Sapp
13. Birthplace: Sherman N. Y.

MOTHER
14. Maiden Name: Mary Brokaw
15. Birthplace: Sherman N. Y.

16 (a) Informant: Lydia Sapp
(b) Address: 1812 Forbush Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/23/46 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Baltimore Co. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1210 E. Fort Ave

19 (a) FEB 20 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1946 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1946, to 2-18 1946 and that I last saw h.i.m. alive on 2-18 1946.

Immediate cause of death: Coronary Thrombosis

Duration

Due to: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 2-11-46

Major findings of operation: Coronary Occlusion

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. S. Lamdin M. D.
Address 1400 N. Carlton St. Date signed 2-18-46

VS 150

X

G37627
CWK-99365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

482 Registered No. G37627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 31- 3- 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Filmot Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amy Ellen Burney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Carl Burney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27-1914

8. AGE: Years	Months	Days	If less than one day
31	3	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David
13. Birthplace Maryland

MOTHER
14. Maiden Name Molly Eyer
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Co. Md.

18 (a) Funeral director Wilson & Son
(b) Address 1217 E. Cold St.

19 (a) FEB 20 1946 (b) Huntington Williamson
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1946, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1946, to Feb. 19 1946, and that I last saw her alive on Feb. 19 1946

Immediate cause of death — Duration
(1) Intestinal obstruction — UNKNOWN
Due to
(2) Carcinoma of Cervix — UNKNOWN
Due to With Metastasis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rush E. Nutterville M. D.
Address Baltimore City Hospitals Date signed 2-19-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37628

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Any person who conceals the cause of death or makes any unnecessary delay in reporting it to the Health Department shall be guilty of a misdemeanor.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) ~~Hospital or~~ institution:
Elmhurst Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Garlock

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
	216-03-8346	Female	White	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1876

8. AGE: Years	Months	Days	If less than one day
69	7	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Dept of Welfare
(b) Address 327 St Paul St

17 (a) Final (b) Date thereof 2/20/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director William Burke Inc
(b) Address 1217 St. Paul St

19 (a) FEB 20 1946 (b) Huntington Williams Registrar
(Make reg'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1946 to Feb 17 1946, and that I last saw h alive on Feb 16 1946

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis - Myocardit	
Due to	
Other Conditions Chr. Arthritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Gaut M. D.
Address 1700 Eutaw Pl Date signed Feb. 17-1946

X

637629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

637629 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The underlining of any cause other than the primary cause will be considered only as information supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 S Paca ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 S. Paca ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Greenwood.

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace Chestertown (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Greenwood
13. Birthplace Chester town

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Ida Greenwood
(b) Address 839 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director Bernard Hale
(b) Address 1000 S. Paca St.

FEB 20 1946 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1946 at 3.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1941 to 2/17 1946 and that I last saw h[illegible] alive on 2/17 1946

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Cardiovascular Renal	5 yr
Due to Diseases	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G Laukaitis M. D.
Address 1000 Washington Blvd Date signed 2/21/46

VS 150

G37630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 ✓

Registered No. G37630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 242 N. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 / 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Susan A. Trounfelker.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Seth E. Trounfelker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1870

8. AGE: Years 75 | Months 11 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Anthony Klotz.
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Seth E. Trounfelker
(b) Address 242 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/46 (month) (day) (year)
(c) Cemetery or crematory Lehigh Cemetery
Location Govldsboro Pa.

18 (a) Funeral director Thomas J. Kenny, Inc.
(b) Address 1600 Hollins St.

19 (a) Date rec'd by Local Registrar FEB 20 1946 (b) Hunting for Millington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946, at 1.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1946 to 2/18 1946, and that I last saw h[illegible] alive on 2/17 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	
Due to Arterial Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Ayton M. D.
Address 2145 N. Balto St Date signed 2/15/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

VS 150

G37631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G37631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Berwick Ave.
(c) Hospital or institution: 771
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Berwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SALLIE ADAMS GULICK

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edwin Gulick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1862

8. AGE: Years 83 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace A. A. Co.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Robert Welsh Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ellen Miller
15. Birthplace Md.

16 (a) Informant Mrs. Harry W. Schuh
(b) Address 2814 Berwick Ave.

17 (a) Burial (b) Date thereof 2/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Asbury Cem.
Location Arnold, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

FEB 20 1946 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1946, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1945 to Feby 17 1946 and that I last saw h[illegible] alive on Feby 17 1946

Immediate cause of death: Metastatic carcinoma Rectum — Duration: 1/2 Month Aug 11/45

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation November 9-1945

Major findings of operation: Exploratory Laparotomy Carcinoma Rectum - Metastasis to Liver and Spleen

of autopsy:

PHYSICIAN
Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Green M.D.
Address 3009 Eastern Ave Baltimore 14 - Md. Date signed 2/19/46

X

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37632+ ✓ G37632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1632

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Floride M. Krampe

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	220-03-9020	Female	White	Widow

6 (b) Name of husband or wife Charles P. Krampe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1900

8. AGE: Years	Months	Days	If less than one day
45	7	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Hub Co.

FATHER
12. Name George H. Hewitt
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Mabel F. Jones
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mabel Hewitt
(b) Address 2209 W. Fayette St.

17 (a) Burial (b) Date thereof 2/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 20 1946 (b) Hunting to Williams M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1946, at 8 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Barbital poisoning
Due to Seconal.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-19-46 8 30 A.M.
(b) Where did injury occur? Home 2209 W. F
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Took Seconal,

23. Signature Benedict Skotarek M.D.
Medical Examiner.
Date signed 2-19-46

637633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 637633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2404 E. North Ave.
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HENRY LACHENMAYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lilly L. Lachenmayer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jyly 7, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Monument Business
11. Industry or business Self

FATHER
12. Name Lewis Lachenmayer
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Koerner
15. Birthplace Germany

16 (a) Informant Mrs. Lilly L. Lachenmayer
(b) Address 2404 E. North Ave.

17 (a) Cremation (b) Date thereof 2/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 20 1946

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1946 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 18 1944 to Feb. 17 1946, and that I last saw h[illegible] alive on Feb. 17 1946

Immediate cause of death	Duration
Myocardial Insufficiency	120 days
Due to Diabetes Mellitus	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Gilbert Lauenberg
Address 2025 E. North Ave. Date signed 2/20/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

637634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 637634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General D. of H

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5418 Jonquil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julian Orr Christian

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Mary Nina Christian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1880

8. AGE: Years	Months	Days	If less than one day
65	5	29	hr. min.

9. Birthplace: Atlanta, Ga.
(Town, county, and state)

10. Usual Occupation
11. Industry or business: Lord Balto. Hotel

FATHER
12. Name: Edward Christian
13. Birthplace: Ga.

MOTHER
14. Maiden Name: Merry
15. Birthplace: Unknown

16 (a) Informant: Mrs. Mary Nina Christian
(b) Address: 5418 Jonquil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 20 1946 (Date rec'd by registrar) (b) [signature] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/46 1946, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy on and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2/19/46

G37635 Ruotolo ✓ G37635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~219 S. Grundy St~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S Grundy St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Ann Ruotolo ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1946

8. AGE: Years | Months | Days: 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Philip Ruotolo
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Christine Czyncoski
15. Birthplace Balto, Md

16 (a) Informant Philip Ruotolo
(b) Address 219 S Grundy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20. 1946 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Monroe St

FEB 20 1946 (Date rec'd) (b) Huntington or Williamsport Md (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946 at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1946 to 2/19 1946, and that I last saw h[illegible] alive on 2/19 1946.

Immediate cause of death: Resp. failure — Duration

Due to: Diarrhea, sclerema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Milton Linthicum M. D.
Address Mercy Hosp Date signed 2/19/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G37636 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 N.Port St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 N.Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M.Zabel

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Chas.E.Zabel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.24,1871

8. AGE: Years	Months	Days	If less than one day
74	3	25	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Laughlin
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Wilcox
15. Birthplace Balto. Md.

16 (a) Informant Mr. Vernon Zabel
(b) Address 1303 N.Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.22/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Hewitt Sons
(b) Address 2024 Orleans St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

FEB 24 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.19,1946 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to Feb 19th 1946, and that I last saw h[illegible] alive on Feb 17th 1946

Immediate cause of death, Chronic bronchitis. — Duration

Due to Asthma & Edema

Due to Endocarditis.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Wade M. D.
Address 3005 Reed St. Date signed 2-20-46.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G37637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Mosher St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Frank Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Bell
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16. (a) Informant Helen Gross
(b) Address 367 N. Fremont Ave

17 (a) Burial (b) Date thereof 2/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pt Ang
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pleasant Ave

19 (a) FEB 20 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946 at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to Fracture of Leg

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/1
(a) Date of injury 12/29/45 at M.
(b) Where did injury occur In front 2136 Fremont Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 2-18-46

VS 151

637638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 637638

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only accepted medical terminology and abbreviations. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2823 Mathews St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) ------
(e) Length of stay in Baltimore (yrs., mos., or days) 78 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Mathews Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country ------

3 (a) FULL NAME: Carvil Stansbury Mason

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Isabelle V. Ross
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1867

8. AGE: Years	Months	Days	If less than one day
78	4	6	-- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: ------

FATHER
12. Name: Carvil S. Mason
13. Birthplace: Baltimore Co., Md.

MOTHER
14. Maiden Name: Catherine Fisher
15. Birthplace: Baltimore Co., Md.

16 (a) Informant: Mrs. Isabelle M. Stricker
(b) Address: 2823 Mathews Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore, Md.

18 (a) Funeral director: W. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) FEB 20 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1946, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1944 to Feb 18 1946 and that I last saw h[illegible] alive on Feb 16 1946

Immediate cause of death	Duration
Chronic Myocarditis	
Chronic Nephritis 5	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Joseph Lowney M.D.
Address 4401 S. Ellwood Av Date signed 2/19/46

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ...ordinary supplies. The

G37639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G37639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Madison & Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No.: (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Harvey F. Lawson

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Lillian L. Lawson
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 29 1891

8. AGE: Years	Months	Days	If less than one day
54	4	21	0 hr. min.

9. Birthplace: Balto Co
(Town, county, and state)
10. Usual Occupation: grocery store
11. Industry or business:

FATHER
12. Name: George L Lawson
13. Birthplace: Balto Co.

MOTHER
14. Maiden Name: Olivia Barkley
15. Birthplace: Md.

16 (a) Informant: Harvey Lawson Jr
(b) Address: Owings Mills

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 22-46 (month) (day) (year)
(c) Cemetery or crematory: All Saints
Location: Reisterstown

18 (a) Funeral director: J. E. Elsine's Sons
(b) Address: Reisterstown Md

19 (a) FEB 20 1946 (Date rec'd by registrar) (b) Hunting for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/19 1946, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1946, to 2/19 1946, and that I last saw him alive on 2/19 1946.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Martin E. Strobel M. D.
Address: Md. Gen. Hospital Date signed: 2/20/46

VS 150

637640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. 637640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 Woodbrook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Geisberger

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1946

8. AGE: Years: 0 | Months: 0 | Days: 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Frederick Geisberger
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Agnes Coleman
15. Birthplace Balto., Md.

16 (a) Informant Mr. F. Geisberger, father
(b) Address 2831 Woodbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Hampden, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 20 1946 (b) [illegible]
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Feby 1946, at 9:00 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation d
Due to Aspiration of food

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 19 Feby 46 9:00 A 13/4 M.
(b) Where did injury occur? 2831 Woodbrook Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury Aspiration of food

23. Signature William H. Hesslink M.D.
Medical Examiner
Date signed 20 Feby 46

X

G37641 WILKINSON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Stricken Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Stricken Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Henry Wilkerson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mattie Wilkinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1872

8. AGE: Years	Months	Days	If less than one day
73	6	21	hr. min.

9. Birthplace Baltimore Co.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Park Board

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mr. William F. Turnbaugh
(b) Address 16 N. Stricker St.

17 (a) Burial (b) Date thereof 2/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 20 1946 (b) Huntington Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1946, at 11.4 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malamud M.D.
Medical Examiner.
Date signed 2-19-46

G37642 ✓ G37642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1561B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Beatrice Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Abe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Canada

MOTHER 14. Maiden Name Laura

15. Birthplace Canada

16 (a) Informant Abe Cohen

(b) Address 2106 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E Balto St

(c) FEB 20 1946 (Date rec'd by registrar) (Signature of) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1946, at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Feb 19 1946 and that I last saw her alive on Feb 19 1946.

Immediate cause of death: Dermatomyositis & cachexia. — Duration: ? 8 months

Due to: Terminal Bronchopneumonia — 3 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Biopsy Nov 19, 1945

Major findings of operation: Skin & muscle changes of dermatomyositis.

Autopsy? Above plus Bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Lunall Katz M. D.

Address Sinai Hosp Date signed 2-19-46

Balt Md

VS 150

37643 153 G37643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1570 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Singer

3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-19-45
8. AGE: Years | Months 6 | Days - | If less than one day hr. min.
9. Birthplace New York (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Arthur Singer
13. Birthplace Canada.

MOTHER
14. Maiden Name Esther Jersey
15. Birthplace Penna

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philg Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St
19 (a) FEB 20 1946 (Date rec'd by Reg.) (b) Signature of Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1946 at 7 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3, 1945 to Feb. 19 1946 and that I last saw her alive on Feb 19 1946

Immediate cause of death	Duration
Increased intracranial pressure	
Due to Operation for subdural Effusion	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-16-46
Major findings of operation: Cerebral atrophy
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Alan Boyle M. D.
Address Johns Hopkins Hospital Date signed 2-19-46

VS 150

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Penalty for wilful violation of this law is $100 fine or imprisonment.

G37644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 E. 31st St. Balto 18 Md
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. William John Costello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mrs. Agnes Costello

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 2/5/71

8. AGE: Years	Months	Days	If less than one day
75	-	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Patrick Costello
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes Lafferty
15. Birthplace Phila. Pa

16 (a) Informant Mrs. Agnes Costello
(b) Address 335 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)

(c) Cemetery or crematory Mem. Gdns.
Location Old Frederick Rd.

18 (a) Funeral director John A. Hogan
(b) Address 800 E. Balto St.

FEB 20 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/1946, at 5:[illegible] PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15/1946 to 2/18/1946, and that I last saw him alive on 2/18/1946.

Immediate cause of death	Duration
Congestive heart failure	4 days
Due to Chronic Myocarditis	?
Due to Generalized Arteriosclerosis	
Other Conditions Renal insufficiency	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. Strickel Jr. M.D.
Address Bon Secours Hosp. Date signed 2/18/46

G37645 ✓ X G37645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

Write the causes of death clearly and legibly. Cause of death is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Tangier
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Parks, Thomas Galloway

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-24-1491

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1887

8. AGE: Years	Months	Days	If less than one day
58	2	7	hr. min.

9. Birthplace Tangier, Va.
(Town, county, and state)
10. Usual Occupation mate
11. Industry or business Seafarer

FATHER
12. Name Edward Parks
13. Birthplace Tangier, Va.

MOTHER
14. Maiden Name Eliza Jane ?
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Tangier Cem.
Location Tangier, Virginia

18 (a) Funeral director Howard Hubbard
(b) Address Crisfield, Md.

19 (a) FEB 20 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1946 to Feb. 19 1946 and that I last saw him alive on Feb. 19 1946

Immediate cause of death	Duration
Intestinal obstruction due to unknown cause	2 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 2/20/46
US Marine Hospital, Balto, Md.

G37646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37646 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Be careful to supply all items.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 N. Calhoun Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 N. Calhoun Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: ANNA ALLEN

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 10, 1881

8. AGE: Years 64 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace: Charlottesville, Va.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: UKNOWN
13. Birthplace

MOTHER
14. Maiden Name: Mary Jane Scott
15. Birthplace: Charlottesville, Va.

16 (a) Informant: Mrs. Ola Cosby
(b) Address: 1703 N. Calhoun Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-1946 (month) (day) (year)
(c) Cemetery or crematory: Family lot
Location: Charlottesville, Va.

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) FEB 20 1946 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1946 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to Feb 19 1946 and that I last saw her alive on Feb 19 1946.

Immediate cause of death	Duration
Cystic-Broncholithiasis	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: W. H. Watts M. D.
Address: 515 Lexington Date signed 2/20/46

VS 150

G37647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G37647 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 46 E. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Simon Kindle

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-14-6571

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy Kindle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1888

8. AGE: Years 57 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Kiddysville, Maryland (town, county, and state)

10. Usual Occupation Painter

11. Industry or business Jobber.

FATHER
12. Name Levi Kindle
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Churchey
15. Birthplace Maryland

16 (a) Informant Lucy Kindle
(b) Address 46 E. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore Md.

18 (a) Funeral director Leonard D. Covington
(b) Address 21 W. 25th St.

19 (a) [illegible] (b) [illegible] M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1946, at 1:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1946, to 2-19 1946, and that I last saw h.[illegible] alive on 2-19 1946

Immediate cause of death: Cardiac Failure — Duration: 1 hr.

Due to: Carcinoma of right lung — Duration: ?

Due to: —

Other Conditions: Pleura of st. upper lobe of lung — Duration: 6 mos.

(Include pregnancy within 3 months of death)

Date of operation 2-19-46

Major findings of operation: Carcinoma of right lung & absent portion

of autopsy: Carcinoma of R. lung.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin A. Johnson M. D.
Address University Hospital Date signed 2-19-46

VS 150

Please write age if especially important. Physicians: please write the correct cause of death clearly and legibly.

G37648 ✓ G37648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. Balto. Md
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George Kroeger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1868

8. AGE: Years	Months	Days	If less than one day
77	9 10	22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Kroeger
13. Birthplace

MOTHER 14. Maiden Name Rose Meyer
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (b) Date thereof Feb. 21, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Peter Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date received by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 19 - 1946, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1946, to Feb 18 - 1946, and that I last saw him alive on Feb 18 - 1946.

Immediate cause of death	Duration
Carcinoma of Stomach	1 yr.
Due to	
Due to Metastasis in Lungs	6 month
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gull Hall M. D.
Address 1631 E North Ave Date signed 2/19/46

G37649 ✓ G37649

AB-74878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs-5mos- 24days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Neville

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Edward Neville (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 1876

8. AGE: Years	Months	Days	If less than one day
69	10	17	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nicholas Furlong
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Sinnott
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

FEB 20 1946 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946 at 12.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24- 1942 to 2-18 1946, and that I last saw h 8F alive on 2-18 1946

Immediate cause of death

	Duration
1. Cerebral Condition resulting from Accident with R.F.	
Due to 2. Generalized Arteriosclerosis	4 wks
Due to (3) Diabetes mellitus	10 yrs.
Other Conditions (4) Carcinoma of Kidney	2 yrs.
(Include pregnancy within 3 months of death)	2 yrs.

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth E. Netterville M. D.
Address Baltimore City Hosp Date signed 2-19-46

VS 150

61

correct age is especially important. Physicians: please write the

637650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. 637650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lyden Haven Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 723 Ramsay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Bury

3 (b) If veteran, name war —

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1940

8. AGE: Years	Months	Days	If less than one day
5	5 4	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elmer Bury
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margie Knight
15. Birthplace Audubon Md.

16 (a) Informant Elmer Bury
(b) Address 723 Ramsay st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Washington Blvd.

18 (a) Funeral director Ambrose, Inc.
(b) Address 414 N. Franklintown Rd.

19 (a) FEB 20 1946 (Date rec'd by registrar) (b) Christopher Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1946, at 6 45 P. M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diphtheria, laryngeal.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Helfrich, M.D. Medical Examiner.
Date signed 2-20-46

VS 151

Per. Howard J. Thomsen, M.D.

G37651
486168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G37651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Middletown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha C. Fisher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: J. H. Fisher
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 8-9-87

8. AGE: Years 58 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Andrew Brumbrack
13. Birthplace Va.

MOTHER
14. Maiden Name Newell
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-46 (month) (day) (year)
(c) Cemetery or crematory River View
Location Strasburg Va.

18 (a) Funeral director Frederick A. Dale
(b) Address 2607 Lombard

19 (a) FEB 20 1946 (Date rec'd by registrar) (b) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-20 1946, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 am-3 1946, to Feb 20 1946, and that I last saw Mrs. alive on Feb-20 1946.

Immediate cause of death: Cyclomphortus, bilateral Cataracts, Chronic Nephritis, bilateral — Duration: Years

Antecedent causes: Arteriosclerotic heart disease, Diabetes, Hernia

Due to

Other Conditions: Abscess, left calf

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address 605 N. Broadway Date signed 2-20-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G376552 Almony ✓ G376552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important. Use only black ink. Typewriting supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Arran Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Merl Atmony

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Hollis Atmony
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1896

8. AGE: Years	Months	Days	If less than one day
49	8	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Nolte
13. Birthplace Maryland

MOTHER
14. Maiden Name Maggie Fowble
15. Birthplace Maryland

16 (a) Informant Mr. Monroe Martin
(b) Address 909 Arran Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 23-46 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial
Location Taylor ave.

18 (a) Funeral director Howard S. Mackenzie
(b) Address White Hall, Md.

FEB 20 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946, at 9 30/ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1945 to Feb 20 1946 and that I last saw her alive on Feb 20 1946

Immediate cause of death Papillary cystadena carcinoma of ovary with metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death).
Date of operation Jan. 21, 1946
Major findings of operation: Papillary carcinoma of ovarian origin
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Cameron Montgomery, Jr. M. D.
Address Union Memorial Hospital Date signed 2-20-46

VS 150

X

G37653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Register G37653

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country None

3 (a) FULL NAME ANTHONY WAICHATIS

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 217-14-3915-A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10, 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	0	10		187 2

9. Birthplace Europe (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Frank Waichatis
13. Birthplace Europe

MOTHER
14. Maiden Name Unknown
15. Birthplace Europe

16 (a) Informant Mrs Helen Kosinsky
(b) Address 626 Washington Blvd City

17 (a) BURIAL (b) Date thereof 2 22 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Charles W. Furhamacher
(b) Address 703 McHenry St.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 27 1946

Huntington Williams, M.D.
Approved:

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1946, at 4:31 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1946, to 2/20 1946, and that I last saw him alive on 2/20 1946

Immediate cause of death	Duration
Uremia	3 days
Due to Arteriosclerotic nephritis	
Due to	
Other Conditions Lobar pneumonia Fracture of L shoulder & Lt leg	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 22/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence February 14, at 1946 M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Street (Specify type of place) While at work? No
(e) Means of injury Fall on floor

23. Signature Grant M. Lamb M. D.
Address Church Home & Hospital Date signed 2/24/46

Robert Lee Graham M.D.

G37654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G37654

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Typewriting is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apt. Charles & 34th Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] McGahan (Mary Helen)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a). Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife G. Harry McGahan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	7	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Francis X Byrne
13. Birthplace Unknown

MOTHER
14. Maiden Name Martha Johnson
15. Birthplace Unknown.

16 (a) Informant Mrs Leonard Mrs Beach
(b) Address 2229 St Paul St

17 (a) Burial (b) Date thereof Feb 21, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North & Greenmount aves

18 (a) Funeral director Ortlip Funeral Home, Inc.
(b) Address 4644 York Rd #12

19 FEB 20 1946 Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946, at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1946, to Feb. 18 1946, and that I last saw her alive on Feb. 18 1946

Immediate cause of death	Duration
Metastatic Ca.	
in vert. L. Hemiplegia, aphasia,	
meningeal, liver, pleura, lungs,	
Due to Endocrinomata, spine	
Due to Ca of breast	
Other Conditions Arteriosclerotic heart disease	
Central nervous system syphilis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Consent to from Next of Kin

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, M.D.
Address Union Memorial Date signed 2/20/46

VS 150

G37655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G37655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 745 N. Kenwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 745 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: EVA ZAWORSKI ROGERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) May 5, 1902

8. AGE: Years 43 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Stephen Zaworski
13. Birthplace: Poland

MOTHER
14. Maiden Name: Anna Krajewska
15. Birthplace: Poznan, Poland

16 (a) Informant: John Rogers
(b) Address: 745 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: German Hill Road

18 (a) Funeral director: M. F. Sadowski & Son
(b) Address: 1801 Eastern Avenue

19 (a) FEB 20 1946 (Date received by Registrar) (b) Huntington Williamsport
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19th, 1946 at 6:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep't, 1945 to Feb 19th 1946 and that I last saw her alive on Feb17th 1946

Immediate cause of death: Primary Carcinoma of Bladder — Duration: 1 yr

Due to: ?

Due to:

Other Conditions: No exceptions

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1901 Eutaw Place, City Date signed 2/20/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37656 ✓ X G37656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age if especially important. Any supplementary supplies...

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Kelwood & Green

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County P.George Co.

(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)

(d) Street No. 317 Talbott Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton L. Donaldson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband~~ or wife Annie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/19/1868

8. AGE: Years 77 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Prince George Co. Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Life Insurance, Agent.

FATHER
12. Name Noah W. Donaldson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Marie A. Sjams
15. Birthplace Maryland

16 (a) Informant DeWitt Donaldson
(b) Address Laurel - Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23. 46 (month) (day) (year)

(c) Cemetery or crematory Ivy Hill.
Location Laurel, Maryland

18 (a) Funeral director J.C. Higginbotham
(b) Address Ellicott City Md

19 (a) (Date received by local registrar) (b) Hunter & Williams, Inc.

FEB 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1946, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1946 to Feb. 20 1946, and that I last saw him alive on Feb. 20 1946

Immediate cause of death	Duration
Shock	
Due to Gastro-Intestinal Hemorrhage	
Due to Probable Carcinoma of Gastro-Intestinal Tract	
Other Conditions Acute dilation of Stomach Enlarged Prostate with distended Bladder	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Regee R. Boone, Jr. M. D.

Address University Hosp. Date signed 2-20-46

G37657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G37657

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 W Conway St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 W Conway St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Eunice Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5:00 AM. 2/19/46

8. AGE: Years	Months	Days	If less than one day
			3 hr. 0 min.

9. Birthplace Baltimore 30, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William Acker
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Lillie Eunice Wilson
15. Birthplace Baltimore, Md.

16 (a) Informant Lillie Eunice Wilson
(b) Address 507 W. Conway St.

17 (a) ____ (b) Date thereof ____
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ____
Location Johns Hopkins Medical School

18 (a) Funeral director Commissioner of Health
(b) Address ____

19 (a) FEB 20 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

FEB 19 1946

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1946, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19, 5:30 AM 1946, to 2/19 9:30 AM 1946, and that I last saw her alive on 5:00 A.M. 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature R B Norment M.D.
M. D.
Address Univ. Hosp. Date signed 2-19-46

5312

X

G37658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G37658

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3435 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Combs

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10, 1946

8. AGE: Years	Months	Days	If less than one day
		1.	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Marida C. Combs
13. Birthplace Florida

MOTHER
14. Maiden Name Mary Yantz
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 20 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 FEB 20 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1946 to Feb. 11 1946 and that I last saw him alive on Feb. 11 1946

Immediate cause of death	Duration
Intracranial hemorrhage	
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hospital Date signed 2-11-46

VS 150

3311

G37659 ✓ G37659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. Balt Gen'l. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Newington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-46

8. AGE: Years | Months | Days | If less than one day: 4 hr. 10 min.

9. Birthplace W. B. P. H.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lawrence Brown
13. Birthplace Balt Md

MOTHER
14. Maiden Name Bertha Brown
15. Birthplace Phila. Pa.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

FEB 20 1946
(Date rec'd by registrar)

Registrar

8310

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-46 1946, at 2:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1946 to 2/18 1946, and that I last saw h[illegible] alive on 2/18 1946

Immediate cause of death	Duration
HYDROCEPHALUS, SPINA BIFIDA.	
Due to	
Due to	
Other Conditions BILATERAL EQUINO VARUS. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Schonfeld
Address West Balt. Gen'l H. Date signed 2/18/46

Johns Hopkins Medical School FEB 1 1946
Commissioner of Health

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637660 — BALTIMORE CITY HEALTH DEPARTMENT — 637660 Registered No.

CERTIFICATE OF DEATH 125a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catan Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 150 S. Morley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Margaret R. Sadler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1929

8. AGE: Years	Months	Days	If less than one day
16 17	3	13	hr. min.

9. Birthplace Balto.
(town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Montgomery - Ward Co

FATHER 12. Name	John
FATHER 13. Birthplace	Md.
MOTHER 14. Maiden Name	Mollie Schalitzky
MOTHER 15. Birthplace	Md.

16 (a) Informant Mrs. Mollie Sadler
(b) Address 150 S. Morley St

17 (a) Burial (b) Date thereof Feb. 23/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 E. Monument Ave.

FEB 20 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1946, at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1946, to 2-19 1946, and that I last saw h[illegible] alive on 2-19 1946.

Immediate cause of death	Duration
Cardiac Resp. Failure	
Due to Complet Hepatic Insufficiency	
Due to Subacut Yellow atrophy of Liver	
Other Conditions Splenomegaly, Anemia	

(Include pregnancy within 3 months of death)
Date of operation 2/16/46
Major findings of operation: Small nodular Liver. Biopsy taken
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas L Carr Jr. M. D.
Address St Agnes Hosp. Date signed 2/20/46

637661 637661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ranmin ave + Dukeland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 68 Prospect Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELBURT A. PAGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1892

8. AGE: Years 53 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Crane Operator

11. Industry or business

FATHER 12. Name Frank A. Page

13. Birthplace Pa.

MOTHER 14. Maiden Name Rosalie Taylor

15. Birthplace Pa.

16 (a). Informant Ruth M. Page

(b) Address 68 Prospect Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Nitzke

(b) Address 410 E Lanvale ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/46 19 , at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16/46 19 to 2/19/46 19 , and that I last saw him alive on 2/19/46 19

Immediate cause of death	Duration
Respiratory Failure	
Due to Hemorrhage	
Due to Mesenteric Thrombosis	2 days
Other Conditions Subsiding Acute Appendicitis	

(Include pregnancy within 3 months of death)

Date of operation 2/16/46

Major findings of operation: Acute Appendicitis Free Fluid in Abdomen

of autopsy: Mesenteric Thrombosis Peritonitis Diffuse

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Donahoe M. D.

Address West Balto Gen Hospital Date signed 2/19/46

VS 150

Item G37662 ✓ G37662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Wilmington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Wilmington Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Margaret Belle Bach

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Andrew Peter Bach

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) October 22 - 1895

8. AGE: Years 70 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Elkridge Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Baltzhauser Carter
13. Birthplace Elkridge Md.

MOTHER
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant Dorothy Lantz
(b) Address 1008 Wilmington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Wetzke
(b) Address 4101 Edmondson Ave

19 (a) ... (b) ... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 - 1946, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 - 1929 to February 18 1946, and that I last saw h[illegible] alive on February 17 1946

Immediate cause of death	Duration
Carcinoma of Uterus	5 1/2 yrs.
Due to	
Due to	
Other Conditions Organic Heart Disease and Hypertension	Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Piland, M.D.

Address 2532 Edmondson Ave Date signed 2-28-46

VS 150

G37663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G37663
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Just Came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Ferndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence Roach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced.
M	W.	M Dora W

6 (b) Name of husband or wife Roach

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1884

8. AGE: Years	Months	Days	If less than one day
61 60	3	5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Hospital Operator

11. Industry or business Bottle washer

FATHER
12. Name William Roach
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Keys
15. Birthplace Baltimore

16 (a) Informant Self
(b) Address Ferndale, Md

17 (a) Burial (b) Date thereof 2/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Harry A Wetzler
(b) Address 401 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946 at 3:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1946 to Feb 18 1946 and that I last saw h[illegible] alive on Feb 18 1946.

Immediate cause of death	Cardiac Resp. failure	Duration
Due to	Hypertensive Cardiovascular disease	over
Due to	Arteriosclerosis	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul R Meyer M. D.
Address Mercy Hosp Date signed 2-18-46

VS 150

(OVER)

X

G37664

BALTIMORE CITY HEALTH DEPARTMENT ✓ G37664

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens Ave & Caton
(c) Hospital or institution:
St. Agnes Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5124 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Munder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife A. Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1881

8. AGE: Years	Months	Days	If less than one day
64 65	2	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Butcher

FATHER
12. Name John G. Munder
13. Birthplace Germany

MOTHER
14. Maiden Name Carolina Kaiser
15. Birthplace Germany

16 (a) Informant Mrs. A. Katherine Munder
(b) Address 5124 Edmondson ave

17 (a) Burial (b) Date thereof Feb. 22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry H. Kuhl
(b) Address 401 Edmondson ave

19 (a) 2/20/1946 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1946, at 11 10 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert E. Gutman M.D.
Medical Examiner.
Date signed Feb. 19 1946.

VS 151

G37685 ✓ G37685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the cause as especially important. Penalty supplied. 1939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Homestead Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 75 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Homestead Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Susanna Lucretia Jefferson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Leonidas D. Jefferson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10-1857

8. AGE: Years 88 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace St. Michaels, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John F. Burkert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Brommel
15. Birthplace Maryland

16 (a) Informant Mrs. Charles M. Smith
(b) Address 718 Homestead Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22-1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3691 Falls Road

19 (a) FEB 20 1946 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18- 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to 2/18 1946 and that I last saw h[illegible] alive on 2/18 1946

Immediate cause of death: Cl. Myocarditis -
Duration: 10 years
Due to: Hypertension
Due to: Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B Harding M. D.
Address 4810 Belair Rd Date signed 2/19/46

VS 150

X

M. D. F. 1268-9

G37665 ✓ G37666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH

Registered No.....

CITY OF BALTIMORE: (No. 310 W. Cold Spring Lane St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Eli CASLOW

(a) Residence: No. 310 W. Cold Spring Lane St., 27 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Anna Catherine Bortner Caslow

6. DATE OF BIRTH (month, day, year) June 23, 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	7	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Railroad maintenance

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Railroad

10. Date deceased last worked at this occupation (month and year) 1925

11. Total time (years) spent in this occupation 35

12. BIRTHPLACE (city or town) (State or country) York Co., Penna.

FATHER

13. NAME Jacob Caslow

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Lucy Hantz

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Grace Caslow (Daughter)

(Address) 310 W. Cold Spring Lane

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Baltimore Cemetery Date Feb. 21 1946

19. UNDERTAKER Burgee Funeral Home

(Address) 3631 Falls Road

20. FILED Feb 21 1946 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 18 1946

22. I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1946 to Feb. 18, 1946

I last saw him alive on Feb. 18, 1946 Death is said to have occurred on the date stated above, at 5.15 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Jan 9 '46

Other contributory causes of importance:

Arteriosclerosis	?
Benign Hypertrophy, Prostate	?

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify.....

(Signed) John W. Parsons M. D.

(Address) 315 Woodbourne Ave.

Instructions on back of certificate. See instructions

37667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G37667

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & Jno St.
(c) Hospital or institution:
Hospital for the Women of Maryland 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Mt Royal Terrace
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Belle Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Lewis H. Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1875

8. AGE: Years	Months	Days	If less than one day
70	6 7	2	hr. min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name George Wigley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sara Reid
15. Birthplace Cumberland Md

16 (a) Informant Louise Evans Bryan
(b) Address 2112 Mt Royal Ave Balt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 103 W. NORTH AVENUE

19 FEB 20 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 February 1946, at 3:12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Feb 1946, to 19 Feb 1946, and that I last saw her alive on 19 Feb 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Pneumonia, bilateral	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H Hemmeter M.D.
Address Hosp. for Women of Md Date signed 2-19-46

X

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

37668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G37668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 8 mo. 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs. 8 mo. 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town New York City (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 West 168th St. (If rural give location)
(f) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clementine Dochez

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9- 1863
8. AGE: Years 83 | Months | Days | If less than one day hr. min.
9. Birthplace Belgium (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Louis Dochez
13. Birthplace Belgium

MOTHER
14. Maiden Name Josephine Dietrick
15. Birthplace United States

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd Baltimore
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)
(c) Cemetery or crematory St. Francis
Location Abingdon - Md.
18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (S. F. WOODEN SUC.) 108 W. NORTH AVENUE
(c) FEB 20 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1946, at 7:57 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1943, to Feb. 18 1946 and that I last saw h.e.r. alive on Feb. 18 1946.

	Duration
Immediate cause of death: General Arteriosclerosis without hypertension	?
Due to: Repeated myocardial infarcts	3 Mo
Due to:	
Other Conditions: Senile Dementia	3 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dawson W. Owens M. D.
Address 533 W. Preston St. Date signed

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write age if especially important.

637669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120a

Registered No. 637669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6503 Armstrong Ave.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto City
(If outside city or town limits, write RURAL and name town)
(d) Street No. 6503 Armstrong Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Joseph Bossiter

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1887

8. AGE: Years 59 | Months 1 | Days 8 | If less than one day — hr. — min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Fire Insurance

11. Industry or business Owner-Hopkins, Colby Purnell Inc.

FATHER
12. Name John Bossiter
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Roffey
15. Birthplace Ireland

16 (a) Informant Mr. John J. Bossiter (Bro.)
(b) Address 6563 Armstrong Ave - City 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)
(c) Cemetery or crematory St. Charles
Location Catonsville, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (C. F. Mowen Son.) 104-6 North Avenue

19 (a) FEB 20 1946 (Date rec'd by Registrar) (b) interment Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19th 1946, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1946 to Feb 19 1946, and that I last saw him alive on Feb 18 1946

Immediate cause of death: Cardiac Syncope — Duration: Sudden

Due to (1) Intestinal Hemorrhage Gastro-Intestinal — 8 ds.

Due to (2) Chronic Bronchitis — many yrs.

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) 12
(e) Means of injury

23. Signature Edward O'Brien M. D.
Address 720 York Rd Date signed 2-19-46
Baltimore 12 Md

VS 150

Please answer all questions as accurately as known to certify supplied. Physicians: please write the causes of death clearly and legibly.

G37670
486828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

× ✓ G37670
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the necessary supplies. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn (b) County
(c) City or town Kulpa, Ford
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hubert Randolph Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ola
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) 4-4-12

8. AGE: Years	Months	Days	If less than one day
33	10	26	hr. min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation Teacher.
11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Lizzie Robinette
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/22/46 (month) (day) (year)
(c) Cemetery or crematory
Location Swaggfield Cemetery

18 (a) Funeral director John J. Speakell Store Inc
(b) Address 1900 Eutaw Place

19 (a) 2 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946 at 12.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1946, to Feb. 20 1946, and that I last saw him alive on Feb. 20 1946.

Immediate cause of death	Duration
Peripheral Circulatory Collapse	10 min
Due to Post Operative Hemorrhage	16 min
Due to Lacerated Portal Vein	4 days
Other Conditions Liver Necrosis Carcinoma Ampulla of Vater	4 days

(Include pregnancy within 3 months of death)
Date of operation 2/20/46 + 2/16/46
Major findings of operation: Carcinoma of Ampulla of Vater
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Consar III M. D.
Address Johns Hopkins Hospital Date signed 2/20

VS 150

J. E. CONSAR X

G37671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1610 Registered No. G37671

Please write the causes of death clearly and legibly. Physicians: please write carefully, important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Baby Boy Gillespie (Cecil Emanuel Gillespie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Baby.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19 1946

8. AGE: Years — Months — Days 1 If less than one day 4 hr. 7 min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Cecil H. Gillespie

13. Birthplace Palmer W. Virginia

MOTHER 14. Maiden Name Wardena E. Tipton

15. Birthplace Baker W. Va.

16 (a) Informant Cecil H. Gillespie

(b) Address 406 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22 1946 (month) (day) (year)

(c) Cemetery or crematory Fairmont

Location Fairmont West Virginia

18 (a) Funeral director Jennie C. Byer

(b) Address 1600 W. North ave.

19 (a) (Date received) (b) Registrar

FEB 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1946 to Feb. 19 1946 and that I last saw h alive on Feb. 19 1946.

Immediate cause of death	Duration
Asphyxia	
Due to Obstruction of Trachea by mucus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Noguera M. D.

Address Maryland Gen. Hospital Date signed 2-20-46

G37672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37672 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes + Dukeland
(c) Hospital or institution BBH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 752 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Albaugh

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband Dessie Albaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10 1882

8. AGE: Years	Months	Days	If less than one day
63	2	9	hr. min.

9. Birthplace Frederick Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Homer Pie Co.

FATHER
12. Name Andrew Albaugh
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Dessie Albaugh
(b) Address 752 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/46 (month) (day) (year)
(c) Cemetery or crematory Utica
Location Frederick Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 21 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 February 1946, at 5:17 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Feb 1946 to 19 Feb 1946 and that I last saw him alive on 19 Feb 1946

Immediate cause of death Ventricular Fibrillation, Duration
Cerebral Accident - Ht Trouble
Due to Hypertensive C.V. Dis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Luther G Albaugh M. D.
Address BBH Date signed 2/20/46

VS 150

Yerby

G37673 — BALTIMORE CITY HEALTH DEPARTMENT — G37673

CERTIFICATE OF DEATH 186a

Registered No.

Please answer questions carefully and completely. Use typewriter if possible. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore City, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Allen Yerby

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Cora Yerby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13th 1858

8. AGE: Years	Months	Days	If less than one day
87	4	7	hr. min.

9. Birthplace: Virginia (town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Grocery

FATHER
12. Name: Joseph J Yerby
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Isabel
15. Birthplace: Virginia

16 (a) Informant: Cora E. Yerby
(b) Address: 2615 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location: Woodlawn Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) FEB 24 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 20 1946 at 9 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12/ 1946 to 2/20 1946 and that I last saw h[illegible] alive on 2/12/ 1946

Immediate cause of death	Duration
Cardiac Respiratory failure	
Due to Hypostatic Pneumonia	
Due to	
Other Conditions Intertrochanteric fracture, left hip (Include pregnancy within 3 months of death)	over

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: accident
(b) Date of occurrence 2/20/46
(c) Where did injury occur? 2615 N. Charles St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Slipped and fell to floor

23. Signature: W. M. Scott
Address: University Hosp. Date signed 2/24/46
Howard J. Mahoney, M.D.

VS 150

637674 ABERNETHY 637674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 105 — Registered No. 637674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Silver Spring Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Abernethy

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 11th 1944

8. AGE: Years: 1 | Months: 7 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thornton Abernethy
13. Birthplace Fullerton Md.

MOTHER
14. Maiden Name Johanna Hoffmann
15. Birthplace Fullerton Md.

16 (a) Informant Thornton Abernethy
(b) Address Silver Spring Rd. Fullerton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) FEB 21 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946 at 10:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h is death on the day stated above; and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Edema of Glottis

Due to Acute Laryngitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 2-20-46

VS 151

G37675 ✓ BALTIMORE CITY HEALTH DEPARTMENT G37675

CERTIFICATE OF DEATH 122B

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only approved abbreviations. Do not use ditto marks.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Millington Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Mac Donald (Vincent Wade) 3rd

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1946

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Vincent W. Mac Donald Jr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen Sperlin
15. Birthplace Maryland

16 (a) Informant Vincent W. Mac Donald Jr.
(b) Address 421 Millington Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Geo. L. Beyer Jr.
(b) Address 1512 Hollins St.

19 (a) FEB 21 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1946, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1946, to 2/19 1946, and that I last saw him alive on 12/19 1946.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Incomplete Invagination	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. D'Elia M.D.
Address St. Agnes Hosp. Date signed 2/19/46

VS 150

G37676 BALTIMORE CITY HEALTH DEPARTMENT G37676

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Bruce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	m

6 (b) Name of husband or wife Eliza
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/1880

8. AGE: Years	Months	Days	If less than one day
65	7	13	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frank Brown
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Allen Brown
(b) Address 1353 N. Stricker St

17 (a) Burial (b) Date thereof 2/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lee Hill Va
Location Va

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pressstman St

19 (a) FEB 21 1946 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1946, at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert L. Fentress M.D.
Medical Examiner.
Date signed Feb. 19 1946.

G37677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

G37677 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write legibly important. Physicians: please write legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rutland Ave Monument St

(c) Hospital or institution: Sinai Hospital 3-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 36

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits write RURAL and give County)

(d) Street No. 1108 E. Lombard St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Morris Rubenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Shandel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county or state)

10. Usual Occupation Book Store

11. Industry or business

FATHER 12. Name Meyer

13. Birthplace Russia

MOTHER 14. Maiden Name Freyna

15. Birthplace Russia

16 (a) Informant Mrs Rosenbaum

(b) Address 1445 N Bentalou St

17 (a) Burial (b) Date thereof 2-21-46 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sinai Israel

Location Southern ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1616 E Baltimore St

19 (a) FEB 21 1946 (b) [illegible] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1946, at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 20 1946, and that I last saw h[illegible] alive on Feb 20 1946

	Duration
Immediate cause of death Cardiac Failure	
Due to Myocardial degeneration Pericarditis with effusion	
Due to	
Other Conditions Bronchial pneumonia	

(Include pregnancy within 3 months of death)

Date of operation Feb 15, 1946

Major findings of operation: Benign prostatic hypertrophy

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis H. Jaul M. D.

Address Sinai Hospital Date signed 2/27/46

VS 150

G37678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G37678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GITTLE SCHUCHALTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Levi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 79 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lucus

13. Birthplace Russia

MOTHER 14. Maiden Name Sosya

15. Birthplace Russia

16 (a) Informant Leo Lewis Schuchalter

(b) Address 2428 Lakewood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Balto St

19 (a) (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1946 at 1230 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1946 to 2-20 1946, and that I last saw h[illegible] alive on 2-20 1946.

Immediate cause of death Hepatic insufficiency — Duration

Due to Carcinoma, liver

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Stanley Roy Sternbach M.D.

Address Sinai Hospital Date signed 2-21-46

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write the age is supremely important. Use

G37679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 N. Kenwood Ave.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LILLIE LAMBDIN MAGEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John T. Magee
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 15. 1862

8. AGE: Years	Months	Days	If less than one day
83	5	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore Bachmann
13. Birthplace Germany

MOTHER
14. Maiden Name Helene ?
15. Birthplace Germany

16 (a) Informant Mrs. Helen M. Russell
(b) Address 3104 Royston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22. 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave & Broadway.

FEB 21 1946 (c) Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18. 1946 at 8.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19, 1946 to Feb. 19 1946, and that I last saw h— alive on Feb. 19, 1946.

Immediate cause of death	Duration
Myocarditis (chronic)	2 mos.
Due to Arteriosclerosis	2,
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Levin jno M. D.
Address 514 Druid Lane Date signed 2/20/46

VS 150

0 X

37680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

637680 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: 8-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE ELIZABETH RUMPF

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife John Frederick Rumpf
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept. 23. 1874

8. AGE: Years	Months	Days	If less than one day
71	6 4	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Hosfeld
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant John Frederick Rumpf
(b) Address 1540 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22 1943 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) FEB 21 1946 (Registered by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19. 1943 at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to 2/19 1946. and that I last saw h.[illegible] alive on 2/19 1946.

Immediate cause of death Hypertensive Cardio Vascular Renal Disease — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny
Address 2208 E Madison St Date signed 2/20/46 M. D.

VS 150

X

Please write plainly with pen and ink. Use no abbreviations. Physicians: please write the causes of death clearly and legibly. Statements of age, as especially important.

637681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. 637681

Please answer all questions in full. Where the space provided is inadequate, continue on separate sheet. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 Mary Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Snyder (JOHN FREDERICK SNYDER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-18-9789

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mary Helen Hamilton
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 30. 1883

8. AGE: Years	Months	Days	If less than one day
62 63	4	20	hr. min.

9. Birthplace Philadelphia Penna
(Town, county, and state)
10. Usual Occupation Auditor
11. Industry or business Warner & Co.

FATHER
12. Name Edward Knight Snyder
13. Birthplace Philadelphia

MOTHER
14. Maiden Name Dorothea Baumbach
15. Birthplace Philadelphia

16 (a) Informant Mrs. Mary H. Snyder
(b) Address 4114 Mary Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23. 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 (a) 8 1 1946 (Date rec'd by registrar) (b) Justin for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1946, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1946 to 2/20 1946 and that I last saw h him alive on 2/19 1946

Immediate cause of death	Duration
Internal Hemorrhage	
Due to Bleeding Peptic Ulcer	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Sonder M. D.
Address Md. Gen'l Hospital Date signed 2/22/46

VS 150

637682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

637682 Registered No.

1139a

Please write the causes of death clearly and legibly. Physicians: please write in capacity in which you sign. Do not abbreviate. Use only accepted medical terminology. Supply all items if possible.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 W. Conway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 W. Conway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Gross

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Raymond Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30-1918

8. AGE: Years	Months	Days	If less than one day
27	9	19	hr. min.

9. Birthplace Annapolis md
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Sims
13. Birthplace md

MOTHER
14. Maiden Name Elizabeth Jackson
15. Birthplace md

16 (a) Informant Elizabeth Simms
(b) Address 406 W. Conway St

17 (a) Burial (b) Date thereof 2-22-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 1142 W Fayette St

19 (a) FEB 21 1946 Huntington Williams
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946, at 2 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1945 to 2/19 1946 and that I last saw h alive on 2/15 1946.

Immediate cause of death	Duration
Sepsis	
Due to Pelvic Abscess 6 wks	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/19
Major findings of operation Ruptured Appendix Hospital - (5 wks)
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Crawley M.D.
Address 1224 W. Lee St Date signed 2/19/46

VS 150

37683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V92B

G37683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Southern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Shadyside Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME C. Ruth Schutz

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. F. Schutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~May~~ Jan. 1st 1904

8. AGE: Years: 42 | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: Harry F. Schmidt
13. Birthplace: Balto. Co. Md

MOTHER
14. Maiden Name: Etenora Herrman
15. Birthplace: Balto. Co. Md

16 (a) Informant: Wm. F. Schutz
(b) Address: 1619 Shadyside Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2 23 46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Balto. Md.

18 (a) Funeral director: Lansdale Funeral Home
(b) Address: 2421 Belair Rd.

FEB 21 1946 (Date rec'd by registrar) Huntington for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 20th 1946, at 5:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 2-20-1946, and that I last saw h[illegible] alive on 2-19-1946

Immediate cause of death: Rheumatic Heart Disease (Mitral Stenosis) — Duration: 2 yrs
Due to: Chronic Bronchial Asthma — 35 yrs
Due to:
Other Conditions: Emphysema and Bronchiectasis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John Costantino, M.D.
Address: 234 S. Conkling St Date signed: 2-20-46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

637684 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age if especially important. Consult necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 ALVARADO SQUARE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 ALVARADO SQUARE
(If rural give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country

3 (a) FULL NAME: HERMAN P. BRILL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	MALE	WHITE	WIDOWER

6 (b) Name of husband or wife MARY BRILL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 26 1857

8. AGE: Years	Months	Days	If less than one day
88	7	22	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation BARBER
11. Industry or business FOR SELF

FATHER
12. Name PHILLIP BRILL
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant WILLIAM A. GEHRMAN (SON IN
(b) Address 5502 GREEN HILL AVE.

17 (a) BURIAL (b) Date thereof FEB. 21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 FEB 21 1946 Hunting Williams Registrar
(Date received by registrar)

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH FEB. 17 1946 at 11/30

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Feb 17 1946 and that I last saw h[illegible] alive on Feb 17 1946;

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to Coronary Heart Block	3 days
Due to Hypostatic Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert Campbell
Address 5707 Kelly Rd Date signed 2-19-46

VS 150

637685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

637685 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALT.O.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William P. Hirshfeld (Jelenoski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife FREIDA HERSHFELD

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 6 1880

8. AGE: Years 65 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name STANISLAUS JELENOSKI
13. Birthplace POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant WILLIAM J. HERSHFELD (SON)
(b) Address 4015 WILSBY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 22/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Geiter Inc.
(b) Address 403 S. WOLFE ST.

17 (c) 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1946, at 5 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intracranial hemorrhage
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 19, 1946
(b) Where did injury occur? 3301 E. Monument St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fall down stairs

23. Signature Benedict Shiftarelic M.D. Medical Examiner.
Date signed 2-20-46.

VS 151

37686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

637686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Gladys Williams.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace SMT S. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Labor

FATHER
12. Name Henry Williams.
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Effa Charles
15. Birthplace S. C.

16 (a) Informant Gladys Williams
(b) Address 413 Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Mount st.

19 FEB 21 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-46 19 , at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Uremia

Due to Chronic Nephritis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2-21-46

Chas. H. — N. Mount St. X

G37687 VI G37687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 176 E. Heath St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 176 E Heath St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence Elmer Crummitt

3 (b) If veteran, name war W.W.I
3 (c) Social Security Account No. 705-10-0829

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband ~~or wife~~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 1890

8. AGE: Years 55 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business B&O R.R.

FATHER
12. Name Denton W. Crummitt
13. Birthplace Frederick Co. Md

MOTHER
14. Maiden Name Mary E. Stimmel
15. Birthplace Frederick Co. Md

16 (a) Informant Mrs. Mary M. Wittmer
(b) Address 413 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Md

18 (a) Funeral director J. Howard Strong
(b) Address 3707 W. North Ave

19 (a) (Date received by registrar) (b) Registrar

21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946, at 5.30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/16 1946 to 2/18 1946 and that I last saw ~~him~~ her alive on 2/15 1946

Immediate cause of death	Duration
Coronary occlusion	15 Min.
Due to Carcinoma of Stomach	1 Mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 2/19/46

G37688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 81a

G37688 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 E. Lombard St
(c) Hospital or institution Bon Sec. Balto. Gen. Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** THOMAS MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1904

8. AGE: Years 41 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

MOTHER / FATHER

12. Name John F Miller

13. Birthplace Balto. Md.

14. Maiden Name Wilhelmina Wiskard

15. Birthplace Balto. Md.

16 (a) Informant Mrs John F Miller

(b) Address 609 McKewen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18 (a) Funeral director John F Henry Inc

(b) Address 716 Light St.

19 (a) (Date rec'd by registrar) FEB 21 1946 (b) Registrar 0

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1946, to 19, and that I last saw h/M alive on 2-20 1946.

Immediate cause of death	Duration
Pneumococcic Meningitis	2 days (?)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.

Address 2 E B St. Date signed 2-20-46

X

G37689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

G37689 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in expectancy important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 Light St.
(c) Hospital or institution: So. Balto. Gen. Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Hollins Ferry Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Humphreys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1878

8. AGE: Years	Months	Days	If less than one day
67	11	9	hr. min.

9. Birthplace District of Columbia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas J. Spilman
13. Birthplace D.C.

MOTHER
14. Maiden Name Julia A. Collins
15. Birthplace D.C.

16 (a) Informant Mrs MARTHA SEARS
(b) Address 2710 Hollins ferry Rd.

17 (a) Burial (b) Date thereof 2/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen HAVEN
Location Ritchie HIGHWAY

18 (a) Funeral director John F Denny Inc
(b) Address 715 LIGHT St

19 (a) 2-21-1946 (b) Baltimore, Md
(Date rec'd by reg'trar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-1946, at 7:28 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4-1946 to 2-18-1946, and that I last saw her alive on 2-18-1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 hrs.

Due to

Due to

Other Conditions: Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Ehrlich M. D.

Address South Balto. Hosp Date signed 2-19-46

VS 150

G37690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37690 Registered No. 1178

Please write the causes of death clearly and legibly. Physicians: please write especially important. Use correct title in supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3438 Sixth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Cornell

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-2216

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1/1888

8. AGE: Years 57 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Restaurant Manager

11. Industry or business

FATHER
12. Name Fred Cornell
13. Birthplace Md

MOTHER
14. Maiden Name Marguerite Vigla
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address St Agnes

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Maryland

18 (a) Funeral director J. J. Filbey Sons
(b) Address 3218 Light St.

19 (a) (b)
(Date received by registrar) Registrar

FEB 21 1946

VS 150

Huntington-Williams, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 19 46, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 19 46, to 2/19 19 46, and that I last saw h. alive on 2/19 19 46

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Generalized Peritonitis	
Due to Ruptured Duodenal Ulcer (2nd Portion)	
Other Conditions Acute Cholecystitis Malignant Hypertension (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Carroll M. D.
Address St Agnes Hosp Date signed 2/19/46

G37691

G37691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1459 Reynolds
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1459 Reynolds (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Dobralsky or Josef Dobrowolski

3 (b) If veteran, name war —

(c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1946 at 1. P. M

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eva Dobralsky
6 (c) If alive, give age years

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1945 to 2-19 1946 and that I last saw him alive on 2-19 1946

Immediate cause of death: Carcinoma of Sigmoid — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

7. Birth date of deceased (mo., day, yr.) not known?

8. AGE: Years: About 67 | Months | Days | If less than one day: hr. min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER 12. Name	? Dobralsky
FATHER 13. Birthplace	Lithuania
MOTHER 14. Maiden Name	not known
MOTHER 15. Birthplace	Lithuania

16 (a) Informant: Mrs Eva Dobralsky
(b) Address: 1459 Reynolds

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23-46 (month) (day) (year)

(c) Cemetery or crematory: Holy Cross
Location: Brooklyn

18 (a) Funeral director: John A. Greffiandes Jr.
(b) Address: 423 S. Paca St

19 (a) (b)

FEB 21 1946

VS 150

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature: A. L. Fallod
Address: 707 Fort Ave. Date signed 2-19-46

Cancer or tumor is especially important. Physicians: please write the causes of death clearly and legibly.

G37692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G37692 Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 E. Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 E. Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magager Haskins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lizzie Haskins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14 1870

8. AGE: Years 75 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Richmond Va.
(Town, county and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Elias Haskins
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie ?
15. Birthplace Va.

16 (a) Informant Elizabeth Hall
(b) Address 1811 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel County

18 (a) Funeral director Byron & Mamie Whyte
(b) Address 721 Aliquith St.

19 (c) FEB 21 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1946 to Feb 18 1946 and that I last saw h.i.m. alive on Feb 18 1946

	Duration
Immediate cause of death Acute myocardial infarction	
Due to Pneumonia lobar. (right).	3wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell M. D.
Address 121 Aliquith Date signed 2-22-46

VS 150

G37693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37693 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as legibly as typewriter supplies. The age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Crowther

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Blanche A. Crowther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24-1876
8. AGE: Years 70 | Months — | Days 26 | If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and State)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

FATHER 12. Name Benjamin Crowther
13. Birthplace Maryland
MOTHER 14. Maiden Name Cepelia Brown
15. Birthplace Maryland

16 (a) Informant Mrs. Blanche A. Crowther
(b) Address 3800 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23-1946 (month) (day) (year)
(c) Cemetery or Crematory Woodlawn
Location Baltimore Co., Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) FEB 21 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20- 1946, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 1929 to Feb 20 1946, and that I last saw h 1m alive on Feb 20 1946.

Immediate cause of death	Duration
Lobar Pneumonia, RL	2 wks
Due to	
Due to	
Other Conditions Arteriosclerotic CVD	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence J. Hammond M. D.
Address 2711 Fallsrd Date signed 2-20 46

VS 150

G37694 / BALTIMORE CITY HEALTH DEPARTMENT / G37694

G37694 CERTIFICATE OF DEATH √160a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DeSoto & Payson Ave.
(c) Hospital or institution: W. Balto. Gen. Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Schandle Decker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1946

8. AGE: Years | Months | Days | If less than one day: hr. 20 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Mark Lionel Schandle Decker
13. Birthplace Waynesboro, Pa.

MOTHER 14. Maiden Name Verna Elizabeth Harmon
15. Birthplace Balto. Md.

16 (a) Informant Mr. Mark Schandle Decker
(b) Address 2404 Chelsea Terrace

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/21/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3800 Hilly Road

18 (a) Funeral director Colwill Conway & Son
(b) Address 901-03 Hollins St.

19 (a) 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1946 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1946 to 2/19 1946 and that I last saw h[illegible] alive on 2/19 1946

Immediate cause of death: 1. Respiratory Failure — Duration

Due to 1. Atelectasis (Fetal) 2. intercranial hemorrh[illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 1. Intracranial Hem. 2. Atelectasis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Lhenfeld M. D.
Address West Balto. Md. Date signed 2/19/46

VS 150

Causes of death should be stated clearly and legibly. Physicians: please write the cause of death clearly and legibly.

637695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

637695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1161 Cleveland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1161 Cleveland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Baerner, Sr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Catherine V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1861

8. AGE: Years 84. | Months 2 | Days 25 | If less than one day 24 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Lumber Clerk
11. Industry or business Retired.

FATHER
12. Name Thomas Baerner
13. Birthplace Germany.

MOTHER
14. Maiden Name Alexander
15. Birthplace Germany

16 (a) Informant Mrs. Catherine V. Baerner
(b) Address 1161 Cleveland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4200 Old Frederick Road

18 (a) Funeral director Albert Cowan & Son
(b) Address 901 W Baltimore St

19 (a) (Date rec'd by registrar) (b) Lexington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19th 1946 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1946 to 2/19 1946 and that I last saw h[illegible] alive on 2/19 1946.

Immediate cause of death	Duration
Acute Cardiac Failure	2 da
Due to Generalized Arterio Sclerotic Cardio-Vascular Disease	5 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph E Lancaster M. D.
Address 901 W Baltimore St Date signed 2/26/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

Please answer all questions as accurately as possible. Physicians: please write the causes of death clearly and legibly.

G37696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G37696 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 670 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 670 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Gill

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife late Geo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29th 1866

8. AGE: Years 79 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Geo Gass
13. Birthplace Germany

MOTHER
14. Maiden Name Antenore
15. Birthplace Germany

16 (a) Informant Mrs Philip G. Gill
(b) Address 1206 Eutaw Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross, Lou
Location Pulaski Highway

18 (a) Funeral director John F. Brown & Son
(b) Address 901-03 Pulaski Hwy

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20th 1946 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1946 to 7/20 1946 and that I last saw h[illegible] alive on 7/20 1946

Immediate cause of death	Duration
Acute Cardiac Failure	1da
Due to Cardiovascular Renal	5yr
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L Lancaster M. D.

Address 670 Washington Blvd Date signed 7/20/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

G37697 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution:
Hospital for Women of Md. 29
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hospital for Women of Md.
(If rural give location)
(e) Citizen of foreign country? Md. No (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Billings

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1946

8. AGE: Years	Months	Days	If less than one day
—	—	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Anthony Michael Billings
13. Birthplace Chios, Greece

MOTHER
14. Maiden Name Fannie Mary Delaro
15. Birthplace Baltimore, Md.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 2/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

FEB 21 1946 (b) [illegible] (Registrar)
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1946, at 9:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15, 1946, to Feb. 18, 1946, and that I last saw him alive on Feb. 18, 1946.

Immediate cause of death	Duration
Respiratory Failure	2 hrs
Due to Anoxemia of Respiratory Centers	2 hrs
Due to Erythroblastosis Fetalis	4 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: PATENT SEPTUM.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. DiPaula M. D.
Address Hospital for Women of Md. Date signed Feb 19, 1946

G37698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37698 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 Belt Street
(c) Hospital or institution:
244
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Belt Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. BAUER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/23/1866

8. AGE: Years	Months	Days	If less than one day
79	10	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Employee Of The Nat-
11. Industry or business ional Stamping Co.

FATHER
12. Name John A. Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Fischer
15. Birthplace Frederick, Md.

16 (a) Informant Family
(b) Address 1735 Belt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director James L. McCully
(b) Address 130 E. Fort Ave.

19 (a) FEB 21 1946 (Date received by Registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1946, at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1946 to Feb. 9 1946, and that I last saw him alive on Feb. 8 1946

Immediate cause of death	Duration
Cardiac thrombosis	1 wk.
Due to Senile myocarditis	1 yr.
Due to Arteriosclerosis	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 E. Randall St. Date signed 2/24/46

X

Sudden deaths require investigation. Physicians: please write the causes of death clearly and legibly.

G37693 BALTIMORE CITY HEALTH DEPARTMENT G37693

CERTIFICATE OF DEATH 91 B Registered No.

Write the causes of death clearly and legibly. Physicians: please write the information requested. This information is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Peach alley
(c) Hospital or institution: 2-3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 6 40 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Peach alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** OScar Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Wrought Iron Clerk Employe

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace Unknown

16 (a) Informant William Jackson

(b) Address 914 Peach Alley.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 23 46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cmty

Location Balto

18 (a) Funeral director Walter R. Driggs

(b) Address 139 W. Hamburg St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21- 19 46 at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8, 19 46, to Feb 21 19 46, and that I last saw h[illegible] alive on Feb 21 19 46

Immediate cause of death Acute Endocarditis — Duration

Due to age

Due to

Other Conditions Kidneys Trouble — Unknown

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work? no

(e) Means of injury

23. Signature James C. Carper M. D.

Address 1016 E. Thrup Date signed 2-24-46

VS 180

G.37700 — Registered No. (37700)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21
(c) Hospital or institution: Lauth Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Pierson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Robert Ranson
13. Birthplace Balto.

MOTHER
14. Maiden Name Nettie Ranson
15. Birthplace Virginia

16 (a) Informant London Bolls
(b) Address 1105 Bruce St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11 23 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calary
Location Balto.
18 (a) Funeral director Watts B. Pugh
(b) Address 1391 W. Hamburg St.
19 (a) (Date rec'd by registrar) (b) Registrar

FEB 21 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1946 at 2:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Cervix

Due to

Other Conditions Anemia
Hydronephrosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarek M.D.
Medical Examiner.
Date signed 2-19-46

X

G37701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G37701

Registered No. .....

Write the causes of death clearly and legibly. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loddie Frank Stupka

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rosanna Stupka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1878

8. AGE: Years	Months	Days	If less than one day
67	11	16	..... hr. ..... min.

9. Birthplace Cleveland, Ohio
(Town, county, and state)
10. Usual Occupation Auto Mechanic
11. Industry or business P. O. Motor Vehicle Service

FATHER
12. Name Mathias Stupka
13. Birthplace Czecho Slovakia

MOTHER
14. Maiden Name Rosa ?
15. Birthplace Czecho Slovakia

16 (a) Informant Mrs. Seward Richie
(b) Address Alaxandria, La.

17 (a) Cremation (b) Date thereof Feb 23, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Loudon Crematory
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) 2-1-1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1945 to 2-20 1946, and that I last saw h[illegible] alive on 2-20 1946.

Immediate cause of death	Duration
Carcinoma of Right Lung	4 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Richie M. D.
Address 1100 N. Charles St. Date signed 2-21-46

X

G3770.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G3770.2

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 Goodwood Gardens
(c) Hospital or institution: none 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Goodwood Gardens (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank K. Duncan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lucy Wright
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 10, 1872

8. AGE: Years	Months	Days	If less than one day
73 71	11	10	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation Engineer - retired
11. Industry or business

FATHER
12. Name George H. Duncan
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hess
15. Birthplace Md.

16 (a) Informant Frank K. Duncan, Jr.
(b) Address 2023 Powhatan Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) H. Covington Williams, M.D. (Date rec'd by registrar) Registrar

FEB 23 1946

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20/46 19 ... at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 2/20 1946, and that I last saw h[illegible] alive on 2/19 1946

Immediate cause of death	Duration
Hypertensive Heart Disease	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack K. Duncan M.D.
Address 6 E. Read St. Date signed 2/21/46

Dr. Morgan

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Space is especially important. Fill

G37703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 S Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 S Payson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Pearl

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-07-6938

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arthur Pearl

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 3, 1883

8. AGE: Years 62 | Months 11 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name August Ebert
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Schelle
15. Birthplace Germany

16 (a) Informant Arthur Pearl
(b) Address 432 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Lepley
(b) Address 2101 Frederick Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1946 at 5:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945, to Feb 20 1946, and that I last saw h[illegible] alive on Feb 19 1946

	Duration
Immediate cause of death: Embolism	1 Day
Due to: Arterio Sclerosis Fibrillating Heart +	10 Yrs
Due to: Myocarditis Diabetes Mellitus	1 Yr
	6 Yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Kahn M. D.

Address 7027 W Pratt St Date signed 2/28/46

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G37704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G37704

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Ida Peffer

3 (b) If veteran, name war —
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11, 1865

8. AGE: Years	Months	Days	If less than one day
80 78	8	10	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation school teacher
11. Industry or business

FATHER
12. Name Phillip Peffer
13. Birthplace Ohio

MOTHER
14. Maiden Name Sarah Ogden
15. Birthplace Pa.

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Stop

17 (a) Burial (b) Date thereof Feb 23, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Cummonwealth Ave

PE [illegible] (b) [illegible]
(Date rec'd by Registrar) Address

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1946, at 12-05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1946 to Feb 21 1946, and that I last saw her alive on Feb 20 1946

Immediate cause of death	Duration
Carcinoma Stomach	2 yrs
Due to	.....
Due to	.....
Other Conditions Metastasis in Lungs	1 month

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature E Gill Hall
Address 1631E North Ave Date signed 2/21/46 M. D.

X

G37705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. G37705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1156 N. Carey St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1156 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Tilghman

3 (b) If veteran, name war: War - No 1

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laura Tilghman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 - 1890

8. AGE: Years 55 56 | Months | Days 26 | If less than one day hr. min.

9. Birthplace Centreville Md (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Wagner Tilghman
13. Birthplace Centreville Md

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Centreville Md

16 (a) Informant Laura Tilghman
(b) Address 1156 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23 - 1946 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Va

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) FEB 22 1946 (Date rec'd by registrar) Huntington Will, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946, to Feb 19 1946, and that I last saw him alive on Feb 16 1946.

Immediate cause of death

Due to: Pulmonary Tuberculosis — Duration: 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. D. Woolridge M. D.
Address 703 W. Lafayette Date signed 2-21-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

63706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Howard Co
(Town, county, and state)

10. Usual Occupation Housew.

11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Howard Co.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Howard Co

16 (a) Informant John Smith
(b) Address 1431 Myrtle Ave

17 (a) Burial (b) Date thereof Feb 25/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Peters
Location

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) FEB 22 1946 (b) Huntington Willis Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-1946, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-1945 to 2-20-1946, and that I last saw h[illegible] alive on 2-15-1946.

	Duration
Immediate cause of death: Coronary Cardiac Renal Disease Hypertension	unk
Due to: Gangrene Left foot	3 mos.
Due to: Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1430 Darley Ave Date signed 2/25/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G37707 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 151
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2646 Oswego Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Orfuss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Irvin Orfuss
13. Birthplace Russia

MOTHER
14. Maiden Name Kala Potasnick
15. Birthplace Russia

16 (a) Informant Marvin Orfuss
(b) Address 2646 Oswego Ave

17 (a) Burial (b) Date thereof Feb, 22, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) FEB 22 1946 (b) Hunter for Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1946 at 8 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1946 to 2/21 1946, and that I last saw h[e]im alive on 2/21 1946.

	Duration
Immediate cause of death Cardiac arrest failure	
Due to Coronary thrombosis (partial) heart block	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin Rudes M. D.
Address Sinai Hosp. Date signed 2/21/46

VS 150

X

G37708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G37708

Write the causes of death clearly and legibly. Physicians: please write in ink. Typewriter is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 W Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alexander Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1886

8. AGE: Years 59 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Daniel Howard

13. Birthplace md

MOTHER 14. Maiden Name Louise Brown

15. Birthplace md

16 (a) Informant Mary Howard

(b) Address 1410 W Franklin St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2/23/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location md

18 (a) Funeral director George H. Nelson

(b) Address 1303 Presstman St

19 (a) FEB 22 1946 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 19 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to 2/19 1946 and that I last saw h[er] alive on Feb 19 1946.

Immediate cause of death: Cerebral Hemorrhage

Due to Hypertensive Cardiac Renal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 hr
4 dy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Hatcher

Address 1725 Linden Ave Date signed 2/21/46 M. D.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G37709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G37709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah J. Bushey

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles B. Bushey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1873

8. AGE: Years 72 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: John H. Caughy
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Sarah Foreman
15. Birthplace: Ireland

16 (a) Informant: Mrs. Sara E. Berry
(b) Address: 2834 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS, INC.
(b) Address: North And Penna. Aves.

19 (a) FEB 22 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1946, at 12 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1946, to Feb 21 1946 and that I last saw h~~e~~ alive on Feb 21 1946

Immediate cause of death	Duration
Cerebral Thrombosis	4 days
Due to	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 720 E 33rd St Date signed 2/21/46

VS 150

Please fill in all items carefully and legibly. Physicians: please write the causes of death clearly and legibly.

G37710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G37710

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 27
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3008 Dupont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Anna E. Drechsler — Annie Estelle Drechsler

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Geo. Thomas
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 2, 1872

8. AGE: Years: 74 75 | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Towson, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Luther Hartzell
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Annie Grahmm
15. Birthplace: Baltimore, Md.

16 (a) Informant: Miss Mildred Drechsler
(b) Address: 2320 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb (month) (day) 1946 (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves. Balto. Md.

19 (a) FEB 22 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/21 1946, at 505 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/45 19__, to 2/21 1946 and that I last saw h[illegible] alive on 2/21 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerosis	
Due to	
Other Conditions Generalized Carcinomatosis	over

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Cecil Rosser M.D.
Address: St. Agnes Hosp. Date signed: 2/21/46

VS 150

G3771.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G3771.1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3600 EDNOR RD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 WEEKS

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town WASHINGTON D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 K. ST. N.E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS W. BAUER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ADELAIDE E. BAUER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 2, 1878

8. AGE: Years	Months	Days	If less than one day
67	9	20	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation U.S. NAVY YARD - RETIRED
11. Industry or business

FATHER
12. Name HENRY BAUER
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name MARTHA ?
15. Birthplace BALTIMORE MD

16 (a) Informant HENRY BAUER
(b) Address 716 CHESAPEAKE AVE

17 (a) BURIAL (b) Date thereof FEB 25, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CONGRESSIONAL
Location WASHINGTON DC.

18 (a) Funeral director DEAL FUNERAL HOME
(b) Address 4512 GEORGIA AVE. N.W.

19 (Date rec'd by registrar) FEB 22 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Feb 1946, at 10:06 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Feb 1946 to 21 Feb 1946 and that I last saw him alive on 21 Feb 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	6 hrs
Due to arteriosclerosis	2 yrs?
Due to Myocarditis	2 yrs?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation None
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature Thomas Hooper M. D.
Address 3934 Ellerslie Ave Date signed 2-22-46

VS 150

Loewe Kamp

63773.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 97

Registered No. 63773.2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton ave, 2nd
(c) Hospital or institution:
Jenkins Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 S. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Joseph C. Loewekamp C.S.S.R.

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~:
M.	W.	single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	23	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant Rev. Father Foerst
(b) Address St. Michael's Church

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director W. W. E. Appel & Sons
(b) Address Lombard & Bway Sts.

19 (a) FEB 22 1946 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1946, to Feb 21 1946, and that I last saw him alive on Feb 21 1946.

Immediate cause of death Cardiac failure — Duration 2 days

Due to Arteriosclerosis — 20 yrs.

Due to

Other Conditions Senility, general — 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Cafritz, M.D.

Address 7 E. Lexington Date signed 2/21/46 M.D.

G37713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Edmond
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Seigel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 23, 1945

8. AGE: Years	Months	Days	If less than one day
0	5	26	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Wilbert Seigel
13. Birthplace Md.

MOTHER
14. Maiden Name Lillian Horseley
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 324 N. Mount St.

17 (a) Burial (b) Date thereof Feb. 22 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2229 N. Schroeder St.

PER (a) (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946 at 10:P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 ,
and that I last saw h alive on Feb 19 1946

Immediate cause of death	Duration
Pneumonia -	
Due to Bacteria possibly tuberculosis -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Butler M. D.
Address Union Hosp. Date signed 2-19-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G37714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec 9
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Stockton St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Baldsbury

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Alice Barnett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1892

8. AGE: Years	Months	Days	If less than one day
53	7	21	....hr. ....min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Henry Salisbury
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Salisbury
15. Birthplace Eastern Shore, Md.

16 (a) Informant Wm. Salisbury (son)
(b) Address 119 S. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23, '46. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location.....

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 22 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946, at 12 50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 20 1946

VS 151

G37715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G37715 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Hillsdale Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Hillsdale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie S. Mitchell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Samuel H. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1868

8. AGE: Years	Months	Days	If less than one day
77	8	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Morell Craig
13. Birthplace United States

MOTHER
14. Maiden Name Fannie S. Davis
15. Birthplace United States

16 (a) Informant Miss Frances Morell Mitchell
(b) Address 3616 Hillsdale Road

17 (a) Burial (b) Date thereof Feb. 23, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) FEB 22 1946 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1946, at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to 2/21 1946 and that I last saw her alive on 2/21 1946

Immediate cause of death	Duration
Chronic Myocarditis	
Chronic Nephritis	
Due to Arteriosclerosis	
Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Lowney M. D.
Address 441 S. Ellwood Ave. Date signed

VS 150

X

63716 Mulb.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

63716 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1846 Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August F. Hohenberg - (WEHRENBERG)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-7965

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie A.

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 12/29/1869

8. AGE: Years 76 | Months 1 | Days 24 | If less than one day — hr. — min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fritz Wehrenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Buddenhagen
15. Birthplace Germany

16 (a) Informant: Marie A. Wehrenberg
(b) Address 1846 Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. B. Wyatt & Son
(b) Address 1310 Eutaw Place

19 (d) FEB 22 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 - 1946 at 12 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardio-vascular disease

Due to

Other Conditions Old myocardial infarction

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Benedict Skiturski M.D.
Medical Examiner
Date signed 2-19-46

VS 151

637717

AB- 99112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 637717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Main St. Turners Station
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Nathaniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- (56 ?

8. AGE: Years 56? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Isle of White Co., Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John R. Porter
13. Birthplace Isle of White Co., Virginia

MOTHER
14. Maiden Name Margaret Johnson
15. Birthplace Isle of White Co., Virginia

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Shipped (b) Date thereof 2/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Smithfield, Va
Location Smith Field, Va

18 (a) Funeral director Ray sue Sanders
(b) Address 1412 E. Preston St.

19 (a) 2-24-1946 (b) [illegible] Registrar
(Date rec'd by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21- 1946, at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7- 1946 to 2-21- 1946 and that I last saw her alive on 2-21- 1946

Immediate cause of death Bronchopneumonia — Duration 3 da.

Due to

Due to

Other Conditions Cerebral vas. acc.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Nusbaum M. D.
Address B.C.H. Date signed 2-22-46

VS 150

107

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G37718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G37718

CHE-99035

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 71- 0- 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 50 W. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Harry Walter Schutz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28-1875

8. AGE: Years	Months	Days	If less than one day
71	0	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Hartman Schutz
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabella Virginia Gottier
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2-23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Carroll Co Md

18 (a) Funeral director Edw C Upton
(b) Address Hampstead Md

19 (a) FEB 22 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1946, at 0100 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1946, to Feb. 19 1946, and that I last saw him alive on Feb. 19 1946

Immediate cause of death A S H D Congestive failure — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M Davis M. D.
Address B. C. H. Date signed 2-20-46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

Abendschoen

G37719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G37719

Please answer all questions in ink. Be sure to state the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 W. University Parkway
(c) Hospital or institution: Jne
(d) Length of stay in hospital or inst. (yrs., mos., or days) Jne
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 W University Parkway (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ursula Abendschoen

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frank Abendschoen
If married, widowed, or divorced, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1860

8. AGE: Years	Months	Days	If less than one day
85	11	11	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Bernard Baylard
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Stochmer
15. Birthplace Germany

16 (a) Informant Ursula Abendschoen
(b) Address 922 W University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Frank A Sparrell
(b) Address Pikesville, Maryland

19 (a) FEB 26 1946 (Date rec'd by Registrar) (b) [illegible] Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1946 at 8.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1946 to Feb 20 1946 and that I last saw h[illegible] alive on Feb 20 1946

Immediate cause of death Cerebral Hemorrhage — Duration 16 day

Due to Generalized arteriosclerosis with hypertension — Duration at least 14 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Jone
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Frank Hewitt M. D.
Address 922 W University Pkwy Date signed 2/21/46

Hewitt

VS 150

37720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146a

G37720 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT + SARATOGA STS.
(c) Hospital or institution: MERCY HOSPITAL 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE 24

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 E. FORT AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNETTE LIMERICK G 4481

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	MARRIED

6 (b) Name of husband or wife ROBERT V. LIMERICK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 19, 1912

8. AGE: Years	Months	Days	If less than one day
33		7	hr. min.

9. Birthplace MARYLAND ST. Mary's (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JAMES G. CLARK
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ARABELLE McKAY
15. Birthplace MARYLAND

16 (a) Informant Robert V. Limerick
(b) Address 23 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB. 25, 1946 (month) (day) (year)
(c) Cemetery or cremator Loudon Park
Location Baltimore

18 (a) Funeral director A. Kemp Evans
(b) Address 1419 Lafayette Ave

19 (a) FEB 22 1946 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 21, 1946, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1946, to 2/21 1946, and that I last saw her alive on 2/21 1946.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to PNEUMONIA	4-5 D
Due to DISTENSION	12 D
Other Conditions EVISCERATION, HYPOPROTHROMBINEMIA (Include pregnancy within 3 months of death)	4 D

Date of operation 2-19-46
Major findings of operation: 7 MO. PREGNANCY & PLACENTA PREVIA
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Odell, Jr. M. D.
Address Mercy Hospital Date signed 2/21/46

Please see that age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G37721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 261 East Hamburg (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** CHARLES O. STRICKER (Oscar B. Streckler)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? — ? ?

8. AGE: Years	Months	Days	If less than one day hr. min.
	About	75 Years	

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home (John G. Strecker)

11. Industry or business

FATHER
12. Name John G. Strecker
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta FEFKE
15. Birthplace Germany

16 (a) Informant Mrs. Matilda Hamill
(b) Address 1631 S. Charles St (niece)

17 (a) Burial (b) Date thereof Feb 23, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.
Location Balto Co., Md.

18 (a) Funeral director J. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) FEB 22 1946 (b) Huntington Wilson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/46 19 at 5 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 2/22/46

VS 151

G37722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G37722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2929 Dillon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 Dillon St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth A. Malone

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 - 1870

8. AGE: Years 75 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER 12. Name Nicholas Malone
13. Birthplace Ireland

MOTHER 14. Maiden Name Johanna Lynch
15. Birthplace Ireland

16 (a) Informant Cath. Malone
(b) Address 2929 Dillon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Hartford Rd.

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Baltimore St.

19 (a) FEB 22 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21 1946, at 1:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Feb 21 1946, and that I last saw h[illegible] alive on Feb 20 1946.

Immediate cause of death	Duration
Cerebrovascular GV disease	12-2-45
Due to Cor. Insufficiency	2-11-46
Due to Congestive Failure	
Due to	
Other Conditions None	

(Incipie pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eli Schimmel M.D.
Address 842 N. Eutaw Date signed 2-21-46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write as especially important. Use only standard abbreviations. Do not use any supplies. The

637723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

637723 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use typewriter if available. Ink must be used. Do not abbreviate.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4230 Sheldon a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Sheldon a
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Pust

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Married

6 (b) Name of husband or wife Frederick a.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1899

8. AGE: Years	Months	Days	If less than one day
46	5	5	hr. min.

9. Birthplace Balto Co. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Elisa Carback
13. Birthplace Balto. Co

MOTHER 14. Maiden Name Annie Connolly
15. Birthplace Ireland

16 (a) Informant Frederick A. Pust
(b) Address 4230 Sheldon a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/46 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Chase Md.

18 (a) Funeral director John A. Hoban
(b) Address 3000 E Baltimore

19 (a) FEB 22 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1946 to Feb 20 1946 and that I last saw h[illegible] alive on Feb 20 1946

Immediate cause of death: Cerebral Hemmorhage — Duration
Due to Hypertension
Due to
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury

23. Signature Walter A Anderson M. D.
Address 306 (Shawan Line Date signed 2/21/46

VS 150

G37724 Gail E. Mitchell X G37724

488097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Canada (b) County
(c) City or town Long Branch Ontario
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 Walnut Crescent
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gail Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-43

8. AGE: Years 2 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Canada
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Percival Mitchell
13. Birthplace Canada.

MOTHER 14. Maiden Name Thelma Ivy
15. Birthplace Canada

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb 22/46
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Park Lawn
Location Toronto, Canada

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 21 1946 at 9.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1946 to Feb. 21 1946 and that I last saw her alive on Feb. 21 1946.

	Duration
Immediate cause of death: Cerebral Thrombosis	
Due to: Post Operative Complication	
Due to: Arteriosclerosis Coronary Cerebral artery	
Other Conditions: Congenital Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation 2-21-46

Major findings of operation: Pulmonic Stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. A. Cooley M. D.
Address The Johns Hopkins Hosp. Date signed 2-21-46

Please answer all questions. Underline the cause of death clearly and legibly. Give only one cause per line. Do not use abbreviations or symbols. Space A is especially important. Physicians: please write the

VS 150

637725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 637725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Tanglewood Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH B. DEERING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late John P. Deering

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 21, 1873

8. AGE: Years 72 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Charles Diffendall
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Alice Haller
15. Birthplace: Maryland

16 (a) Informant: Mrs. Evelyn Duvall
(b) Address: 25 Tanglewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: 3801 Frederick Road

18 (a) Funeral director: Harry H. Witzke
(b) Address: 4101 Edmondson Avenue

FEB 23 1946 (Date rec'd by Registrar) Harry H. Witzke

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6, 1936 to Feb. 20 1946, and that I last saw her alive on Feb. 20, 1946.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease. Congestive Heart Failure	3 wks.
Due to	
Due to	
Other Conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Eugene H. Kemp M.D.
Address: 3030 Edmondson Ave. Date signed 2/22/46

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37726

BL - 99302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

148a

Registered No. G37726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 wk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Jean Kofers

2/16/46 842556

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1924

8. AGE: Years 21 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Omaha, Neb.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Feb 23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave Extended

18 (a) Funeral director Williams Cook Inc
(b) Address 217 St Paul Street

19 (a) FEB 23 1946 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1946, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1946 to Feb. 17 1946, and that I last saw h er alive on Feb. 17 1946.

Immediate cause of death — Duration

Edampsia

Due to

Due to

Other Conditions Pregnancy 36 weeks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: fatty degeneration liver

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roger T Coates M. D.

Address 6 E Pleasant Date signed 2/24/46

over

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37727 Kemp G37727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvinia Kemp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records
(b) Address 1708 Eutaw Place

17 (a) Burial (b) Date thereof Feb 23 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wuedfeld
(b) Address 914 Greenmount Ave

19 (a) FEB 23 1946 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1946 at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 - 1945 to Feb 21 1946. and that I last saw h[illegible] alive on Feb. 21 - 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Adv. Atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Jacobs M.D.
M. D.
Address 1700 Eutaw Pl. Date signed 2-22-46

VS 150

G37728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G37728 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2308 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Augusta M. Kramer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick L. Kramer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 28, 1866

8. AGE: Years 79 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: At. Home
11. Industry or business

FATHER
12. Name: George Rau
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Carriare
15. Birthplace: Germany

16 (a) Informant: Miss Edith A. Framer
(b) Address: 2308 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23, 1946 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves.

FEB 23 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21 19 46 at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7/46 19 , to 2/21/46, and that I last saw h[illegible] alive on 2/20/46 19

Immediate cause of death	Duration
CARCINOTIC EXHAUSTION (POISON)	24 hrs.
Carcinoma Face	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place).
(e) Means of injury
23. Signature Henry C. Harris, M.D.
Address 9 W Mount Pl Date signed 2/21/46

VS 150

G37729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G37729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belonna Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Naylors Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet S. Gessford

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter W. Gessford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1880

8. AGE: Years 65 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Royston
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel Lowe
15. Birthplace Md.

16 (a) Informant Mrs. Claude Crandall
(b) Address Naylor's Lane Pikesville

17 (a) Burial (b) Date thereof 2/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Freeland Balto. Co. Md.

18 (a) Funeral director Wm. Tyson Lowe
(b) Address Northern Ave

19 (a) FEB 22 1946 (Date rec'd by registrar) (b) Filed by Wm. Tyson Lowe

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 to Feb 21 1946
and that I last saw h[illegible] alive on Feb 21 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 10 days
Due to: Uterus Adenoma — ??
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel H. Coleman M. D.
Address 5611 Reisterstown Rd Date signed

VS 150

Samuel H. Coleman

G37730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37730 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga & Orleans
(c) Hospital or institution: West Baltimore Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon S. Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1878

8. AGE: Years	Months	Days	If less than one day
67	5 9	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Govt. Employee
11. Industry or business

FATHER
12. Name Gustavus Gibson
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Elizabeth Kirwan
15. Birthplace Va.

16 (a) Informant Mr. Wm. R. Gibson
(b) Address 2714 Maryland Ave.

17 (a) Burial (b) Date thereof 2/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto.

19 (a) FEB 23 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 February 1946 at 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Feb 1946 to 21 Feb 1946, and that I last saw him alive on 21 Feb 1946

Immediate cause of death

	Duration
Due to Cerebral Accident	
Due to Cerebral Hemorrhage	
Due to Left Hemiplegia	
Due to Hypertension & C.V. Dis.	
Other Conditions Contributing	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester A. Hall Jr. M. D.
Address West Bal. Gen Hosp Date signed 2/24/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37731

JL - 99036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G37731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 447 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Potes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Pearl (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1877

8. AGE: Years	Months	Days	If less than one day
68	7	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business P R R

FATHER
12. Name James
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Clark
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F. Henry Inc
(b) Address 2 E. Eight St.

19 (a) FEB 23 1946 (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1946 19 ; at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4, 1946 to Feb. 22 1946, and that I last saw h[illegible] alive on Feb. 22 1946

Immediate cause of death: (a) Uremia → Duration 2 days.
(b) Hydronephrosis 2 yr.
(c) Pyelonephritis 2 yr.
Due to (d) Ca. of Prostate 4 yrs.
(e) Diver 2 mos.
Due to (5) Diverticulum 7
Other Conditions Rectum 7

(Include pregnancy within 3 months of death)
Date of operation 2-17-46
Major findings of operation: Carcinoma of prostate with stenosis through [illegible]
of autopsy: See Diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh E. Rothwell M. D.
Address Baltimore City Hosp Date signed 2-22-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G37732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1448 Boyle St.
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1448 Boyle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ella Daniels

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter Emerson Daniels
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) March 14, 1882

8. AGE: Years	Months	Days	If less than one day
63	11	7	hr. min.

9. Birthplace N. J. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name George Smith
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Walter E. Daniels
(b) Address 1448 Boyle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory Jordan Cem.
Location Near Lakeland, Comm.

18 (a) Funeral director John F Glenny Inc
(b) Address 714 Light St.

19 (a) (Date rec'd by registrar) (b) Wm. Fillmore Register

FEB 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1946, at 8 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1945, to 2-21 1946, and that I last saw h[illegible] alive on 2-21 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Arteriosclerosis	1 Yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Sallod M. D.
Address 707 Fort Ave. Date signed 2-21-46

Coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

G37733 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 South Streeper Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 South Montford
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IGNACY LISIECKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1877

8. AGE: Years	Months	Days	If less than one day
68 S.M.T.			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Lisiecki
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Novak
15. Birthplace Poland

16 (a) Informant Kamila Wachanski (daughter)
(b) Address 603 S. Eaton Street

17 (a) Burial (b) Date thereof 2-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory POLISH NATIONAL
Location BALTO COUNTY, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 So Clinton st

19. FEB 22 19 (b) Huntington Ave Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/46 19 at 10:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation due to Clothes line around neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/21/46 7 P.M.
(b) Where did injury occur? 643 South Streeper
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self Inflicted

23. Signature John R. Weirs M.D.
Medical Examiner
Date signed 2/22/46

G37734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 97

G37734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Glenmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Glenmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME G. Francis Meyers.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-07-8827

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lily M. Meyers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3 1869

8. AGE: Years 76 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Retired Printer

11. Industry or business

FATHER 12. Name Charles F. Meyers Jr.
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine B. Hirsh
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Plitt.
(b) Address 2513 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Ave.

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 23 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1946, to Feb 20 1946 and that I last saw h. i. M. alive on Feb 20 1946

Immediate cause of death Uremia — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 2-22-46

Burial permit issued by Hunter for Hillis, Registrar

X

The causes of death clearly and legibly. The age is especially important. Physicians: please write the ca

G37735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G37735

Please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 W. Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3519 W. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Assunta Zianni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Zianni

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1882

8. AGE: Years 63 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER 12. Name Felice A. Di Nardo

FATHER 13. Birthplace Italy

MOTHER 14. Maiden Name Domenica Fattara

MOTHER 15. Birthplace Italy

16 (a) Informant Joseph Zianni

(b) Address 3519 W. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Woodlawn Balto. Md.

18 (a) Funeral director Lazzaro Bros.

(b) Address 505 Park Eighth Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1946, at 12 30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to Feb 21 1946 and that I last saw h[illegible] alive on Feb 21 1946.

Immediate cause of death: Paralysis — Duration 3 day

Due to: Cerebral Hemorrhage — 3 day

Due to: Hypertension Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Mears, M. D.

Address 512 Park Eighth Ave. Date signed Feb 21 46

637736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 637736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.U.A.
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eva E. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17th 1867

8. AGE: Years 69 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Newcastle England (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Johns Hopkins Univ.

FATHER
12. Name John Smith
13. Birthplace England

MOTHER
14. Maiden Name
15. Birthplace England

16 (a) Informant Mrs Eva E. Smith
(b) Address 1230 N. Broadway

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb 25 1937 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Hanover Pa

18 (a) Funeral director Leo F. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Delivered by) (Registrar) (b)

FEB 23 1937

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1937 at 9:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Arteriosclerotic CV Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gubinski M.D.
Medical Examiner.
Date signed 2-22-46

X

G37737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G37737

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Kirby Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-0356

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Married

6 (b) Name of husband or wife Esther Smith

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 1, 1881

8. AGE: Years	Months	Days	If less than one day
64	11	18	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Brieller Smith Co

FATHER
12. Name Emanuel Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Cecilia Frazier
15. Birthplace Maryland

16 (a) Informant Esther Smith
(b) Address 529 Kirby Lane

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Feb. 23-46
Location Baltimore City

18 (a) Funeral director Geo. G. Kelson
(b) Address 803 Preston Ave., St.

19 (a) FEB 23 1946 Date received by local registrar — Wilmer [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1946, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions Hypertrophy & dilatation of heart, chronic nephritis, arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 2-23-46

VS 151

637738 637738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County md
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Oldham st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1942

8. AGE: Years 3 | Months 10- | Days | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John K. Andrews
13. Birthplace Greece

MOTHER
14. Maiden Name Mary
15. Birthplace Baltimore Md.

16 (a) Informant Nick Hatzias
(b) Address 406 S. Oldham st

17 (a) Burial (b) Date thereof 2-23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Greek Cemetery

18 (a) Funeral director Lambros Fun. Home Inc.
(b) Address 440 - E. North ave

19 (a) 2 23 1946 Huntington Williams M.D.
(date received by registrar) (registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH [redacted] 1946, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1946 to 2-21 1946, and that I last saw h[redacted] alive on 2-21 1946.

Immediate cause of death: Cardiac failure — Duration

Due to Hepato- and Splenomegaly & Myeloid anemia

Due to Cooley's Anemia.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address St Agnes Hospital Date signed 2/21/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly

637739

JL - 99252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 637739 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1747 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1865

8. AGE: Years	Months	Days	If less than one day
81	0	24	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jerry Hamilton
13. Birthplace Va.

MOTHER
14. Maiden Name Diana
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomfield Ave
(c) Date received by Registrar FEB 23 1946 Washington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1946 at 6:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1946, to Feb. 19 1946, and that I last saw him alive on Feb. 19 1946

Immediate cause of death	Duration
Bronchopneumonia	
Due to A.S.H.D. Decompensation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy A.S.H.D., nephrosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marguerite Davis M. D.
Address B C H Date signed 2-20-46

VS 150

(OVER)

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G377-40 ✓ 937 G377-40

CWK-99244 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas McQuillon ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3-1871 ?

8. AGE: Years	Months	Days	If less than one day
74	6	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas McQuillon
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Federal Rd
18 (a) Funeral director Edward Loudon
(b) Address 2359 Orleans Blvd
19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 23 1946 Huntingtown, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1946, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1946, to Feb. 19 1946, and that I last saw h 1m alive on Feb. 19 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to A S H D Congestive failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy? Autopsy Edema Hydrothorax (Xr.)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Margaret McInnis M. D.
Address B C H Date signed 2-20-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. ...tion should be carefully supplied. The

X

G37741

486858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G37741

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Juanita Fowlkes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married.

6 (b) Name of husband or wife Howard -
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) 6-15-28.

8. AGE: Years	Months	Days	If less than one day
17.	8	7	hr. min.

9. Birthplace Ky.
(Town, county, and state)
10. Usual Occupation HOME - wife
11. Industry or business

FATHER
12. Name Everett Proffit
13. Birthplace Ky.

MOTHER
14. Maiden Name Edna Adkins
15. Birthplace Ky.

16 (a) Informant Doctor
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Dove Hill Ky.
Location Olive Hill Ky.
18 (a) Funeral director John C. Mitchell Sons
(b) Address 1900 Eutaw Place
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22nd 1946, at 10. P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan-15 1946 to Feb-22 1946, and that I last saw him alive on Feb-22 1946

Immediate cause of death	Duration
Tuberculosis, pulmonary, active	
Due to	
Due to	
Other Conditions Pregnancy (spontaneous abortion) (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Gilbert J. Vezburgh M. D.
Address Johns Hopkins Hospital Date signed 2/23/46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered

Please answer all questions in full. Use extra sheet of paper if necessary. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-mos 25days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 157 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE MILLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Edward Mill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-1886

8. AGE: Years 59 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Md., Baltimore (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business City Hospitals

FATHER
12. Name George Weber
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine Mattaush(D)
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals(Re
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-46 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cem.
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 28 1946

VS-190

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 19 46, at 2.37 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 12-26- 19 45 to 2-21 19 46
and that I last saw h alive on 2-21- 19 46

Immediate cause of death: Pulmonary Embolism — Duration: 1 week
Due to:
Due to: Adenocarcinoma of Stomach With Metastasis
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 1-2-46
Major findings of operations: Carcinoma of Stomach with metastases
of autopsy: As diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rush E. Butterworth M. D.
Address Baltimore City Hosp. Date signed 2-22-46

637743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

637743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Penna. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Penna. Ave. g
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Humstead

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. ?????????

6 (b) Name of husband or wife ??????????????????

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 189?

8. AGE: Years 54 | Months 8 | Days 12 | If less than one day hr. min. 1891

9. Birthplace Eastern, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name UKNOWN
13. Birthplace

MOTHER
14. Maiden Name UKNOWN
15. Birthplace

16 (a) Informant Mrs. Cora Shields
(b) Address 1847 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 23 1946 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946, at 7.05 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to Feb 19 1946 and that I last saw him alive on Feb 19 1946

Immediate cause of death Acute Cardiac Asthenia — Duration 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. G. Haurant M. D.
Address 632 Frankhurst Date signed 2/24/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

637744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. 637744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norbert W. Dorsey

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
--	214-01-8481	Male	White	Married

6 (b) Name of husband or wife Viola W. Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1892

8. AGE: Years	Months	Days	If less than one day
53	9	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Norbert Dorsey
13. Birthplace ---

MOTHER
14. Maiden Name Alice Nagel
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Viola W. Dorsey
(b) Address 2425 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25. 46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henrich Sons
(b) Address 2024 Orleans St.

19 (a) (Date received by local registrar) FEB 23 1946 (b) Huntington Willis

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1946, at 4.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1945, to Feb. 21 1946, and that I last saw h[illegible] alive on Feb. 20 1946.

Immediate cause of death	Duration
1) Cerebral Hemorrhage	2 days
Due to Hypertension	5 yrs.
Due to Heart Disease	
Other Conditions --	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation None
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Chambers M. D.
Address 4104 Liberty Hts. Date signed 2/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37745

JL - 99226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G37745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 10
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 951 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Crane

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26 1887

8. AGE: Years	Months	Days,	If less than one day
58	4	24	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lawrence
13. Birthplace S. C.

MOTHER
14. Maiden Name Lou ?
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave,

17 (a) Burial (b) Date thereof Feb 23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Wm. Peter A. Elliott & Son
(b) Address 1129 N. Caroline St.

19 (a) (b) Huntington Williams, Mgr.
(Date received by local registrar) (Signature of local registrar)

FEB 23 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1946 19 , at 6:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 19 46 to Feb. 20 1946, and that I last saw h alive on Feb. 20 19 46

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert L. Copeland Jr. M. D.
Address Balt City Hosp. Date signed 2/2/46

X

correct age is especially important. Physicians: please write the

G37746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G37746

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. If unknown, state approximate. If not applicable, write none.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12da
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County HARFORD
(c) City or town BEL AIR
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY HELEN McGREEVY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife THOMAS HENRY McGREEVY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	12	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name DANIEL IGNATIUS CHRYSTAL
13. Birthplace Balto.

MOTHER
14. Maiden Name LAURA V. MILES
15. Birthplace Balto.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Co. Md.

18 (a) Funeral director Hubert F. Watkins
(b) Address Delta, Penna.

19 (a) (b) Huntington Williamsport

FEB 23 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1946, at 8:50A

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1946 to 2-23 1946, and that I last saw her alive on 2-23 1946.

Immediate cause of death Uremia — Duration

Due to Chr. nephritis

Due to Arteol., generalized

Other Conditions Hypertens. CVD.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dayle D. Arnold, M.D.
Address Date signed 2-23-46

X

63744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. 63744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James W. Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1928

8. AGE: Years	Months	Days	If less than one day
17	8	25	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name James A. Hill
13. Birthplace Md.

MOTHER 14. Maiden Name Laura S. Wamer
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1528 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Fayette Ave.

18 (a) Funeral director L. McAvoy
(b) Address 30 E Fayette

19 (a) FEB 23 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1946 at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Peritonitis due to gunshot wound of chest and abdomen.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was (primary) ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 10 1946 a.a.a.
(b) Where did injury occur? Glen Burnie, Md.
(c) Did injury occur at home or farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot by rifle

23. Signature Benedict Skolarsky M.D. (Medical Examiner)
Date signed 2-23-46

VS 151

637748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

637748 X V 157E

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write. Correct age is especially important. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York city.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 299 E. Botanical Square
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Karen Marshall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12.13.45.

8. AGE: Years | Months: 2 months 10 | Days | If less than one day: hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Marshall
13. Birthplace N.Y.

MOTHER
14. Maiden Name Hattie Gilbert
15. Birthplace austria

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) removal (b) Date thereof 2-28-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Montefiore
Location Long Island N.Y.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) MAR 1946 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2.23 1946 at 10 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2.22 1946 to 2-23 1946 and that I last saw h-d alive on 2.22 1946.

Immediate cause of death	Duration
Cardiac failure	
Surgical shock	
Due to Congenital Malformation of Heart	
Due to Complete Pulmonary atresia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-22-46
Major findings of operation: attempted anastomosis sub-clavian art. & Pul. artery
of autopsy Atresia of pulmonary artery

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard J. Humphries M.D.
Address Johns Hopkins Hospital Date signed 3/22/46

Howard J. Humphries, M.D. X

VS 150

G37749
44288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

Registered No. G37749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Gettysburg (If outside city or town limits, write RURAL and give town)
(d) Street No. R. D. # 5 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy J. Lorhen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-1909

8. AGE: Years	Months	Days	If less than one day
36	10	18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Nurse. J.H.H.
11. Industry or business

FATHER
12. Name Mark W Lorhen
13. Birthplace N.Y.

MOTHER
14. Maiden Name Edith Timm
15. Birthplace Md.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/46 (month) (day) (year)
(c) Cemetery ~~crematory~~ Bryerlea Memorial Park
Location Bryerlea Pa.

18 (a) Funeral director J. Milton Bender
(b) Address 125 Carlisle St. Gettysburg Pa

19 (a) FEB 24 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1946, at 6.16 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1946, to Feb. 23 1946, and that I last saw h. A. alive on Feb. 23 1946.

Immediate cause of death	Duration
Tetanus from pelvic abscess.	5 day.
Due to Pelvic abscess caused undetermined.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/22/46
Major findings of operation Pelvic abscess
of autopsy Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. L. Hopkins M. D.
Address J. Hopkins Hospital Date signed 2/23/46

VS 150

G37750

BALTIMORE CITY HEALTH DEPARTMENT ✓ G37750 Registered No.

CERTIFICATE OF DEATH 121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Lanvale Ave
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Shannon Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. DONALD MASON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Kamilla Mason
nee Prettyman 6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1909

8. AGE: Years	Months	Days	If less than one day
36	2	29	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation machine operator
11. Industry or business Paid - Avery & Co.

FATHER
12. Name Alexander Mason
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Fagan Backer
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Leonard
(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof 2-23-46 (month) (day) (year)
(c) Cemetery or crematory Cloverhill
Location Pennsylvania

18 (a) Funeral director John G. Connelly
(b) Address 416 Eastern Ave. City

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1946, to Feb 22 1946, and that I last saw him alive on Feb 22 1946.

Immediate cause of death	Duration
Uremia	5 days
Due to Paralytic ileus	12 days
Due to Generalized peritonitis	15 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/8/46
Major findings of operation: Acute appendicitis perforation & generalized peritonitis
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward M. Leonard M. D.
Address Church Home & Hospital Date signed 2/22/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

G37751 G37751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Information required must be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 4 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (Catonsville)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Paradise Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret E. Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Arthur Pitts Clarke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 14, 1873

8. AGE: Years	Months	Days	If less than one day
72 - 4	5	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward Coale
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Young
15. Birthplace Maryland

16 (a) Informant Mr. Norman Clarke
(b) Address 18 N. Symington Ave., Catonsville

17 (a) Burial (b) Date thereof Feb. 25, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamborn
(b) Address 4510 Liberty Heights Ave.

19 (a) (b) Huntington Mills Received
(Date rec'd by registrar)

FEB 24 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1946 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 2/22 1946 and that I last saw h. alive on 2/22 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 hrs

Due to: Hypertension C.V. Disease

Due to:

Other Conditions: Renal Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strober M. D.

Address Md. Genl. Hospital Date signed 2/23/46

G37752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G37752
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Park Ave
(c) Hospital or institution: Friends Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude A Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married, widowed~~, or ~~divorced~~ Single

6 (b) Name of husband or wife —
6 (c) If ~~alive~~, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18-1867

8. AGE: Years 79 | Months 04 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Alexandria Va
(Town, county, and state)

10. Usual Occupation Retired Nurse
11. Industry or business

FATHER
12. Name Elisha Janney Miller
13. Birthplace Va

MOTHER
14. Maiden Name Betty A Loy.
15. Birthplace Va

16 (a) Informant Miss Mabel M Rea
(b) Address 1405 Mt Royal Ave

17 (a) Burial (b) Date thereof Feb 25-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Southern Methodist
Location Alexandria Va

18 (a) Funeral director Berg and Gore
(b) Address 2324 N. Charles St.

19 (a) FEB 24 1946 (b) Harrington Williams Registrar
(Date rec'd by Local Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Feby 1946, at 4:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work? ...
(d) Means of injury

23. Signature William J Holbrook M.D.
Medical Examiner.
Date signed 23 Feb 46

G37753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G37753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: 67 Years | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Israel Rubin

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Leah

15. Birthplace Russia

16 (a) Informant Lillian Robinson

(b) Address 2028 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mount Carmel

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1809 E Balto St

(c) FEB 24 1946 (Date rec'd by registrar) (d) Arrington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1946 at 8:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1946 to 2-23 1946 and that I last saw h alive on 2-23 1946.

Immediate cause of death Uremia + cardiac failure — Duration

Due to Arteriosclerotic cardiovascular degeneration

Due to

Other Conditions Carcinoma of the hepatic flexure of the colon

(Include pregnancy within 3 months of death)

Date of operation 2-19-15

Major findings of operation: Carcinoma of colon with metastasis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L Rosenthal M. D.

Address Sinai Hospital Date signed 2-24-46

Enter age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37754 ✓ G37754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write th

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 155 Clifton ave
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 155 Clifton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham L. Merr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Freda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Harry Mitchel
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude
15. Birthplace Russia

16 (a) Informant Freda Merr
(b) Address 155 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1630 E. Balto St

19 (a) 2-24-1946 (Date received by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22- 1946, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to 2/22 1946, and that I last saw h. alive on 2/19 1946.

Immediate cause of death Coronary Artery Thrombosis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 2904 Rueth Rd. Date signed 2/24/46

VS 150

X

G37755 ✓ G37755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Daytona Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Vanger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hyman I. Levy
13. Birthplace Russia

MOTHER
14. Maiden Name Celda
15. Birthplace Russia

16 (a) Informant Harry Vanger
(b) Address 3425 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rodeph Shalom
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1429 E. Balto. St

19 (a) (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1946, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5 1945 to 2-23 1946 and that I last saw h[illegible] alive on Feb. 23 1946

Immediate cause of death: Chr. cerebral vascular disease — Duration
Parkinson's Disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin
Address Levindale Date signed 2/23/46

G37756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G37756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dunbar
(c) Hospital or institution: Balt Hosp Dem Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3718 Columbus Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yetta Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Henry Miller
(b) Address 2542 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-46 (month) (day) (year)

(c) Cemetery or crematory United Hebrew
Location Washington Blvd

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1409 E Balto St

19 (a) FEB 24 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Feb 1946 to 22 Feb 1946 and that I last saw h e alive on 22 Feb 1946

Immediate cause of death: Cerebral Accident — Duration:

Due to: Hypertensive Arteriosclerotic C.V. Dis

Due to:

Other Conditions: Diabetes Mellitus Pneumonia, bronchial
(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo H. A. Israel Jr. M. D.
Address Balt Dem Hosp Date signed 2/24/46

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G377757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G377757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Randolph

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/15/08

8. AGE: Years	Months	Days	If less than one day
37	0	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert E. Randolph
13. Birthplace Md.

MOTHER
14. Maiden Name Dora E. Hackley
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Feb. 26, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rockville Hill
Location Maryland

18 (a) Funeral director Raymond Barber
(b) Address Laytonsville Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946, at 5.00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull: Intracranial Hemorrhage, traumatic
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 20, 1946 8:30 P.M.
(b) Where did injury occur? 1717 Madison Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt Force

23. Signature Robert E. Gutelius M.D.
Medical Examiner.
Date signed Feb 23 1946

Fracture for Williams, M.E.

G37758 | BALTIMORE CITY HEALTH DEPARTMENT | ✓ G37758

CERTIFICATE OF DEATH

63a | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 N Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Femal | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George Redmond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7 1872

8. AGE: Years 70 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Jarboro N C
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Charles ROSS

13. Birthplace Va

MOTHER 14. Maiden Name Annie Henderson

15. Birthplace Va

16 (a) Informant Henry Redmond

(b) Address 504 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Balto Co Md

18 (a) Funeral director A Hyatt Williams

(b) Address 1515 McElderry St

FEB 24 1946 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1946, at 10.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sunday 1946, to Feb 20 1946; and that I last saw h[illegible] alive on Feb 20 1946.

	Duration
Immediate cause of death: Uraemia	2 days.
Due to: Cerebral apoplexy.	3 wks.
Due to: Hypertension	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell M. D.
Address 121 Augusta Date signed 2-23-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37759 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Vavrina

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1878

8. AGE: Years	Months	Days	If less than one day
67	9	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Frank Vavrina
FATHER 13. Birthplace Vienna

MOTHER 14. Maiden Name Mary Kulaksik
MOTHER 15. Birthplace Vienna

16 (a) Informant Earl Vavrina
(b) Address 10 N Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C Mosura
(b) Address 3800 E Baltimore St

19 (a) FEB 24 1946 (b) [illegible] for William [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1946, to Feb 21 1946, and that I last saw h[im] alive on Feb 21st 1946

Immediate cause of death
Pulmonary Embolism

Due to Cardiac Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration of Illness
8 days
2.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. J. Jenkins M. D.
Address 100 N. Milton Date signed 2/24/46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G37760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G37760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 E. 38th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 E. 38th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Price

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 78			hr. min.

9. Birthplace Ind. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant J. Howard Holzer

(b) Address 622 Melvill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26/46 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Homeland Cem.

18 (a) Funeral director John A. Horan

(b) Address 426 Greenmount Ave.

19 (a) FEB 24 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/46 1946 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29th. 1945 to Feb. 21st 1946.
and that I last saw him alive on Feb. 21st 1946.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Arteriosclerosis	unknown
Due to — — — — — — —	
Other Conditions Carcinoma of Liver	about 10 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo W. Hungate M.D.
M. D.

Address 401 E. 25th. St. Date signed 2/23/46.

VS 150

Complete as to cause of death clearly and legibly. Physicians: please write the causes of death in the space provided. The certificate is especially important.

G37761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G37761 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1833 Druid Hill Ave.
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA JONES

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Benjamin Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1875

8. AGE: Years 70 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Sample
13. Birthplace Va.

MOTHER
14. Maiden Name UKNOWN
15. Birthplace

16 (a) Informant Alphonsus Jones
(b) Address 1833 Druid Hill Ave.

17 (a) Burial (b) Date thereof Feb. 25, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hobland
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 24 1946 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1946, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Feb 21 1946 and that I last saw her alive on Feb 20 1946

Immediate cause of death Cardio Vascular Renal Disease — Duration 6 mo's

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1928 Pa Ave. Date signed 2/23/46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G37762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Maund Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Maund Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Weber

3 (b) If veteran, name war No | 3 (c) Social Security Account No. 215-10-9465

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1870

8. AGE: Years 75 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Roofer

11. Industry or Business Self Roofing Co

FATHER 12. Name George Webb
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Catherine Young
15. Birthplace Paris France

16 (a) Informant Charles Weber
(b) Address 506 Maund Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md

18 (a) Funeral director C. Samuel Evans
(b) Address 1400 N Charles St

19 (a) (Date received by registrar) (b) Herrington Williams registrar

B 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Feb 23 1946, and that I last saw h/[illegible] alive on Feb 20 1946

Immediate cause of death	Duration
Bilateral advanced Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Fuller M.D.
Address 320 Cathedral ave Date signed 2/23/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G37763 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) Life 3 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3.(a) FULL NAME Adele Merrill Orendorf

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph C. Orendorf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 87 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Henry Merrill
13. Birthplace Balto Md

MOTHER
14. Maiden Name Martha Lewis
15. Birthplace Md

16 (a) Informant Mrs. Frederic Young
(b) Address 1523 22nd St. N.W. Wash. DC.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Henry W. Perkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by local registrar) (b) Huntington Williams Asst. Registrar

FEB 24 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21 1946, at 4.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1946, to 2-21 1946, and that I last saw her alive on 19

Immediate cause of death	Duration
BRONCHOPNEUMONIA	4 days
Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	2 yrs
Due to GENERALIZED ARTERIO SCLEROSIS	15 yrs -
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Klenman M. D.
Address 2803 Edmondson Ave Date signed 2-23-44

X

G37764
4884666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G37764
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Elliott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rita Mazurkiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-31-44

8. AGE: Years	Months	Days	If less than one day
1	10	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mazurkiewicz
13. Birthplace Mass.

MOTHER
14. Maiden Name Pearl Kleinsmith
15. Birthplace Mass

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location German Hill Rd

18 (a) Funeral director John T. Duda
(b) Address 2829 Eldon St

19 (a) 2-24-1946 (b) Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-23 1946, at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-19 1946, to Feb-23 1946, and that I last saw h[illegible] alive on Feb-23 1946.

Immediate cause of death: Respiratory failure — Duration: 4 hours
Due to: tuberculous meningitis — 2 weeks
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 2-21-46
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address Johns Hopkins Hospital Date signed 2-25-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37265 — 170c — Registered No. G37265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Rutland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM THOMAS

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife. ~~Feb 12, 1942~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1942

8. AGE: Years	Months	Days	If less than one day
4	-	9	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Audrey Grimes
15. Birthplace Bates, Md

16 (a) Informant Audrey Grimes
(b) Address 1028 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph S. Lucky & Sons
(b) Address 304 N. Central Ave

FEB 24 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1946 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-19-46 at 4:20 p. M. 8/7
(b) Where did injury occur? West on Chase at Rutland Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 2-22-46

VS 151

637766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

637766 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 6
(d) Street No. 537 N. McMechen St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Manning

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	married

6 (b) Name of husband or wife Albert H. Manning
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1888

8. AGE: Years	Months	Days	If less than one day
58	0	5	hr. min.

9. Birthplace Hartsville, South Carolina (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Chas Farmer
13. Birthplace Hartsville, S.C.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Albert Manning
(b) Address 537 Mc Mechen St

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/24/46 (month) (day) (year)
(c) Cemetery or crematory Florence Ct
Location
18 (a) Funeral director Chas H. Albrecht
(b) Address 1200 McCulloh
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1946 at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19-1946 to 2-23-1946 and that I last saw her alive on 2-23-1946.

Immediate cause of death	Duration
Cerebral Accident	
Due to Hypertensive Cardio-vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John George McDonald M. D.
Address 847 N. Carey Date signed 2/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G37767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37767 Registered No.

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Green Haven,
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLE C. SOLLENBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-26-7861

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Daniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1909

8. AGE: Years	Months	Days	If less than one day
36	3	6	hr. min.

9. Birthplace Chambersburg, Pennsylvania
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business White Swan Tavern, A.A. Co.

FATHER
12. Name Chauncey P. Smith
13. Birthplace Chambersburg, Pennsylvania

MOTHER
14. Maiden Name Minnie Ellis Bear
15. Birthplace Fort Loudon, Pennsylvania

16 (a) Informant Chauncey P. Smith
(b) Address 143 Kennedy St., Chambersburg,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn R.F.D.
18 (a) Funeral direc Thomas W. Singleton
(b) Address Glen Burnie, Md
19 (a) 2-24-1946 (b)
Date rec'd (by Registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1946 at Midnight P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed head

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: a.a.-Hon
(a) Date of injury 2-21-46 at 11:30 P. M.
(b) Where did injury occur? Old Annapolis Rd. & Marley Creek
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. & Auto. Collision

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-22-46

G37768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G37768 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Vincent Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Vincent Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Leanna Winston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John D. Winston
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1918

8. AGE: Years 27 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Wakefield N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Columbia ? N.C.
15. Birthplace

16 (a) Informant John D. Winston
(b) Address 1627 Vincent Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/46 (month) (day) (year)
(c) Cemetery or crematory
Location Wakeforest. N.C.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) (b)

FEB 26 1946

Burial for Mrs. Winston

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/1946 at 3.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15/1945 to 2/22/1946 and that I last saw h[illegible] alive on 2/21/1946

Immediate cause of death	Duration
Carcinoma of Breast	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Haverkamp
Address 450 W. Biddle St. Date signed 2/23/46

X

G37769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G37769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 E. 22nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph T. Whittle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

June 26, 1897

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
63	7	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Clerk

FATHER
12. Name Charles W. Whittle
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Winifred Roan
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Doris Anderson
(b) Address 515 E. 22nd St

17 (a) Burial (b) Date thereof 2-25-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flippen & Fleming
(b) Address 1416 Light St.

19 (a) FEB 25 1946 (b)
(Date received by registrar)

Flemington for William Brightful

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1946 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1945 to Feb 21 1946 and that I last saw h[illegible] alive on Feb 21 1946

	Duration
Immediate cause of death Chronic Ulcerative Colitis	3 mos
Due to - Bronchial Asthma	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. J. Whittle M. D.
Address 1279 William St Date signed 2/24/46

correct age is especially important. Physicians: please write the

G37770 ✓ X 93D G37770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. H

Please write the causes of death clearly and legibly. Physicians: please write age is especially important. Use necessary abbreviations. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 S. Light St.
(c) Hospital or institution: Bay. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Brooklyn, Baltimore Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY GALLOWAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 | 1871

8. AGE: Years: 66 | Months: 4 | Days | If less than one day ... hr, ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Galloway
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Mikel
15. Birthplace Germany

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 2-25-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Thomas J. Fleming
(b) Address 1426 Light St.

19 (a) (b) Registrar
(Date rec'd by Registrar)

B 25 1946

Thomas Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1946, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1946, to 2-22 1946, and that I last saw h. alive on 2-22 1946

Immediate cause of death	Duration
Hypostatic pneumonia	2 mos.
Due to Cerebro-vascular accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Steinberg M. D.

Address S.B.C.H. Date signed 2-22-46

X

G37771 ✓ × G37302 7/

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. /

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace B. Ecker

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Dawson Ecker
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) APRIL 30-1871

8. AGE: Years 74 | Months 10 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Charles Keffer
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Bare
15. Birthplace Maryland

16 (a) Informant Grace Ecker
(b) Address NEW WINDSOR, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 26-46 (month) (day) (year)
(c) Cemetery or crematory PIPE CREEK CEM
Location UNIONTOWN ROAD

18 (a) Funeral director D. D. HARTZLER & SONS
(b) Address UNION BRIDGE & NEW WINDSOR MD

19 (a) ... (Date received by registrar) (b) ... Registrar

VS-160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1946, at 1 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1946 to 2/24 1946 and that I last saw h[illegible] alive on 2/24 1946

Immediate cause of death Pneumonia Aspirated — Duration

Due to Hemorrhage Gastric ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Baggott M. D.
Address Westminster Date signed 2/26/46

G37772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37772 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 W Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmond J Murphy.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212098791

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1900

8. AGE: Years	Months	Days	If less than one day
45	11	28	hr. min.

9. Birthplace Baltimore
(Town, county and state)

10. Usual Occupation Laundry Light

11. Industry or business American Home Pkg

FATHER
12. Name Edward F. Murphy
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna O'Connor
15. Birthplace Baltimore

16 (a) Informant Elizabeth L Murphy
(b) Address 1523 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 1946 (month) (day) (year)
(c) Cemetery or crematory Mem Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A Weyforth
(b) Address 4101 Edmondson Ave

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb (21) 20 1946 at 6:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1946 to Feb 26 1946, and that I last saw him alive on Feb 26 1946.

Immediate cause of death Coronary occlusion — Duration 4 hours.
Due to coronary sclerosis
Due to
Other Conditions Hypertension heart disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Pearman
Address 206 S. Gilmor St Date signed M. D. 2.27.46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37773 G37773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 330 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Queen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. David B Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	WHITE	Married

6 (b) Name of husband or wife PEARL Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/10/1874

8. AGE: Years	Months	Days	If less than one day
72	7	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wm. FORD.
13. Birthplace Delaware

MOTHER
14. Maiden Name Rachel Ford.
15. Birthplace Delaware

16 (a) Informant Hospital Records
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 27, 1946 (month) (day) (year)
(c) Cemetery or crematory [redacted] St. Paul
Location KENT Co. Md

18 (a) Funeral director J. WILLIS WELLS
(b) Address CHESTERTOWN, Md.

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Huntingtown Hills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1946, at 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1946 to 2/24 1946, and that I last saw him alive on 2/24 1946.

	Duration
Immediate cause of death: Broncho pneumonia	5 days
Due to: Influenza	2 wks.
Due to:	
Other Conditions: Healed fibroid tuberculosis;	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. Liddell Jr. M. D.
Address Bon Secours Hosp. Date signed 2/24/46

G37774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. G37774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME EMILIE I. EBAUGH

3 (b) If veteran, name war: NV

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			..... hr. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Reuling
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Yungle
15. Birthplace Germany

16 (a) Informant Nora Hampton
(b) Address 2020 Dukeland Street

17 (a) Cremation (b) Date thereof Feb. 25, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto., Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) FEB 25 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1946 at 9:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intracranial hemorrhage
Due to .....

Other Conditions Small pulmonary Embol:
Compound fracture both Legs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-16-46 at 7 P. M. 11/4
(b) Where did injury occur? Linden Ave. & Dolphin St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.
(hit and run)

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2-23-46.

G37715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G37715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd
(c) Hospital or institution:
Ventura Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Ijam Market
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma D Stier

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1867

8. AGE: Years 78 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Ijam Market Md (Town, county, and state)

10. Usual Occupation Teacher School

11. Industry or business

FATHER 12. Name Hamilton Stier
13. Birthplace Md

MOTHER 14. Maiden Name Rebecca Barbour
15. Birthplace Md

16 (a) Informant Douglas Stier
(b) Address Sudbrook Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 2/25/40

(c) Cemetery or crematory Ijam Market
Location Ijam Market Md

18 (a) Funeral director Fulton Funeral Home
(b) Address 2217 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1940 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1940 to Feb 22 1940, and that I last saw h[illegible] alive on Feb 21 1940.

Immediate cause of death	Duration
Lobar Pneumonia	6 hrs
Due to Coronary Thrombosis	
Due to Arteriosclerosis	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence no at — M
(c) Where did injury occur? — —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature C O Hearn M.D.
Address 709 E Lexington St Date signed 2/27/40

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

637776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. 637776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 Bolton st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Bolton st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah (Sallie) Rebecca Hutson

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Jan 15th 1857
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/1857

8. AGE: Years	Months	Days	If less than one day
89	1	6	hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Housewife

FATHER
12. Name Thos. H. Merritt
13. Birthplace a. a. Co. Md.

MOTHER
14. Maiden Name Eliza Ann Hawkins
15. Birthplace a. a. Co. Md.

16 (a) Informant John R. Hutson
(b) Address 2821 Guilford Ave

17 (a) Burial (b) Date thereof 2/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 517 St. Paul St.

FEB 25 1946 (b) Huntington Hillis
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21st 1946, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1946 to Feb. 21 1946, and that I last saw her alive on Feb. 20 1946.

Immediate cause of death	Duration
Arteriosclerosis	?
Cardio-vascular disease	
Due to Synovitis of knee ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Hess M. D.
Address 5106 Hayfield Rd. Date signed 2/25/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G37777
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Laurens Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH MAC MURRAY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/45

8. AGE: Years	Months	Days	If less than one day
	3	3	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Ralph Mac Murray

13. Birthplace B. Va.

MOTHER 14. Maiden Name Ruth Butts

15. Birthplace Baltimore Md

16. (a) Informant Ruth Mac Murray

(b) Address 1316 Laurens St

17 (a) Burial, cremation or removal Arbutus Mem Gdns (b) Date thereof 2/26/46
(month) (day) (year)

(c) Cemetery or crematory [redacted]

Location Baltimore Md

18 (a) Funeral director Mrs Geo A. Yates

(b) Address 631 Lan & Hill Ave.

19 (a) FEB 25 1946 (b) [illegible] Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1946, at 8:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed 2-23-46

G37778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G37778 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 561 Mosher Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERNICE SMITH (BERNICE KNOX CRAWFORD)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
21			hr. min.

9. Birthplace Maryland
10. Usual Occupation Waitress (Town, county, and state)
11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Burgie Brown
15. Birthplace Maryland

16 (a) Informant Mr. Eugene Crawford
(b) Address 561 Mosher Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1946, at 1:30a.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-21-46 at 11:30 P. M.
(b) Where did injury occur 1436 Pennsylvania Ave. (Pa. Ave. Tavern)
(c) Did injury occur at home, on farm, industrial place, in public place? Place of Employment While at work? Yes
(d) Means of injury Stabbed during altercation

23. Signature Benedict Skiteretis M.D. (Medical Examiner)
Date signed 2-23-46.

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 637719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Calif. (b) County Alameda
(c) City or town Alameda
(If outside city or town limits, write RURAL and give town)
(d) Street No. 838 Laurel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (ELBURT Richards Elliott) Capt. Albert R. Elliott ELBURT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Douglas Elliott

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1946

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation U.S. - Captain

11. Industry or business U.S.

FATHER
12. Name Leslie Elliott
13. Birthplace California

MOTHER
14. Maiden Name Cora Spencer
15. Birthplace California

16 (a) Informant Med. Dept. Officer
(b) Address Baltimore

17 (a) (Burial) (Burial, cremation, or removal) (b) Date shipped Feb 25 1946 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location Alameda Co. Calif.

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W North Ave.

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946 at 1:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fraton M.D.
Medical Examiner.
Date signed 2-20-46

G37780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

V G37780 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information cannot be correctly supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33 Sts.
(c) Hospital or institution:
Union Memorial Hosp 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City.
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 E 39th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles Bevan Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mrs Charles B Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 3 - 1874

8. AGE: Years	Months	Days	If less than one day
71	6	24	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name John C. Clark
13. Birthplace Washington - D. C.

MOTHER
14. Maiden Name Emma Bevan
15. Birthplace Balto - Md.

16 (a) Informant Mrs Chas. B. Clark
(b) Address 507 E 39th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn

18 (a) Funeral director Sherwood & Co.
(b) Address 1080 N Howard.

19 (a) FEB 25 1946 (Date rec'd by local registrar) (b) Livingston Williams M.D. (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 24 - 1946, at 11 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 13 - 1946, to Feb - 24 - 1946, and that I last saw h-e alive on Feb - 24 - 1946.

Immediate cause of death	Duration
a Arteriosclerotic Cardio-renal Disease	
Due to	
Due to	
Other Conditions Appendicitis Abscess	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George M Colflesh M. D.
Address 6 W H Date signed 2/27/46

VS 150

X

G37781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G37781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Genl Hosp 24 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Seaman aboard S.S. Campa, Docked at Fairfield.
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Kristiansand, Norway.

3 (a) FULL NAME Severre Bodin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 9, 1898

8. AGE: Years 47 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Kristiansand Norway (Town, county, and state)

10. Usual Occupation Mil Engineer

11. Industry or business Steamship

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Domingo Cuesta
(b) Address Baltimore Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-20-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilson & Co
(b) Address 217 E Pond St

19 (a) FEB 25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1946, at 3 45 A.M.

21. I certify that I took charge of the remains described above, held an Insp-Jy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Extensive burning of body, Impossible recognition.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury 2-19-46 at Bet: 1 & 2 A.M.
(b) Where did injury occur? Aboard ship - S.S. Campa
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Burned in Conflagration of room.

23. Signature Benedict Distaselie M.D. Medical Examiner.
Date signed 2-19-46

VS 151

G37782 5914 G37782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 258 N. Pine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James A. McLloyd Smith, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-45

8. AGE: Years	Months	Days	If less than one day
	1	25	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER
12. Name James McLloyd Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Adel Harris
15. Birthplace Md.

16 (a) Informant Sadie Brown
(b) Address 250 N. Pine St.

17 (a) Burial (b) Date thereof 2-25-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md

18 (a) Funeral director Stallings & Garbson
(b) Address 916 Penna ave

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Waiting for Mail (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946 at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymicus – by complications

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratton M.D. Medical Examiner.
Date signed 2-23-46

VS 151

G37783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. G37783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2540 E Baltimore
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Kentucky Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L Rohde / Rohde

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Lillian Hammann
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 24 1881

8. AGE: Years	Months	Days	If less than one day
64	4	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Ship builder
11. Industry or business

FATHER
12. Name Charles L Rohde
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Kolsch
15. Birthplace Germany

16 (a) Informant Mrs Lillian Rohde
(b) Address 2222 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 25 1946 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946, at 3-05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20- 1945 to 2-22- 1946 and that I last saw him alive on 2-22- 1946.

Immediate cause of death	Duration
Generalised Carcinoma- to s/s	9-20-45
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury 1-3
23. Signature Fulton C. Lang M. D.
Address 2117 Belair Rd Date signed 2-23-46

VS 150

correct age is especially important. Physicians: please write the

G37784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194B

G37784 Registered No.

Write the causes of death clearly and legibly. Ages, if a specialty important. Physicians please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 W. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Richmond.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ESSIE S. L. CALISCH

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Edward N. Calisch.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 17, 1877.

8. AGE: Years	Months	Days	If less than one day
68	11	7	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles E. Straus,
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Fannie Rose,
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. M. L. Breitstein,
(b) Address 2405 W. Rogers Ave.

17 (a) Removal & Burial (b) Date thereof 2.25.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Cemetery
Location Richmond, Va.

18 (a) Funeral Edward Sonnenschein's Sons
(b) Address 1902 Eutaw Place.

19 (a) FEB 27 1946 (b) [illegible] Registrar
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946, at 60. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1946 to Feb 25 1946 and that I last saw h[illegible] alive on Feb 24 1946.

Immediate cause of death: Angina Pectoris

Duration
4 years

Due to #
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mrs. M. L. Breitstein M. D.
Address 2110 Carterdale Rd. Date signed 2/25/46

G37785 G37785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 E. 33rd Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bruce

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 1946

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Maryland Gen Hospital (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles R. Bruce
13. Birthplace Port Royal Va.

MOTHER
14. Maiden Name Hattie Wash
15. Birthplace Richmond Va.

16 (a) Informant Mr. Charles R. Bruce
(b) Address 1807 E 33rd Street

17 (a) Transit Permit (Burial, cremation, or removal) (b) Date thereof 2/25/46 (month) (day) (year)
(c) Cemetery or crematory Bruce Burial Plot
Location Bowling Green Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) FEB 25 1946 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1946, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1946, to 2-24 1946, and that I last saw him alive on 2-24 1946.

Immediate cause of death: Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. V. Stanley M.D. M. D.
Address Maryland Gen Hosp Date signed 2/24/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G37786 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2801 W. NORTH AVE
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE, (IC) 6
(If outside city or town limits, write RURAL and give town)
2801 W. NORTH AVE
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ALBERT CHAMBLY

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife: LYDIA C. CHAMBLY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) NOV. 12, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	11	hr. min.

9. Birthplace MARYLAND (City, county, and state)
10. Usual Occupation CLERK
11. Industry or business MARYLAND BISCUIT CO.

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant MRS. LYDIA C. CHAMBLY
(b) Address 2801 W. NORTH AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory MOUNT OLIVET
Location 2930 FREDERICK AVE
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address NORTH & PENNA AVES. BALTIMORE, 17, MD.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 23 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945, to Feb 22 1946 and that I last saw him alive on Feb 22 1946.

Immediate cause of death: Chronic cardio vas dis — Duration: ?
Due to
Due to
Other Conditions: Carcinomatosis — Duration: 2 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature X Ernest H. Kalter, M. D.
Address 1730 Poplar Ln Date signed 2-27-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37787

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Hemlock Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Hemlock Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Louise Yingling

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry C. Yingling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1875

8. AGE: Years	Months	Days	If less than one day
70	4	15	hr. min.

9. Birthplace Hampstead, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. H. Bower
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary C. Wilhelm
15. Birthplace Balto. Co. Md.

16 (a) Informant Mr. Wlmer S. Yingling
(b) Address 8314 Liberty Road

17 (a) Burial (b) Date thereof 2/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director Wm. C. Tickner & Sons.
(b) Address North & Pa. Aves.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 25 1946

Waiting for Affidavit

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1946 at 12.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1935 to 19
and that I last saw h alive on Feb 23 19 46

Immediate cause of death Coronary Thrombosis — Duration 1 hr.
Due to Diabetes mellitus — 7 yrs
Due to Generalized arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Alessi
Address 6217 Harford Rd Date signed Feb 25 46

Dr E. J. Alessi

G37788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G37788
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Days
(e) Length of stay in Baltimore (yrs., mos., or days) Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Dillon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Richard Henningan

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 28 1945

8. AGE: Years [redacted] | Months 7 mo | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Elmer Henningan
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Spellman
15. Birthplace Md. (Deceased)

16 (a) Informant ELMER HENNINGAN(FATHER)
(b) Address 3114 DILLON ST.

17 (a) BURIAL (b) Date thereof FEB.25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly & Geisler Inc.
(b) Address 403 S.WOLFE ST.

19 (a) FEB 25 1946 (b) Huntington for Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1946 to 2-23 1946 and that I last saw h[illegible] alive on 2-23 1946

Immediate cause of death: Respiratory Failure — Duration

Due to: Tuberculosis Meningitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas E. Bradlaw M. D.
Address University Hosp. Date signed 2-23

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G37789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Reg Fnd G37789 — Registered No. 131a

The information should be carefully supplied. Every item should be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1564 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 McElderry St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Annie Berry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1911

8. AGE: Years	Months	Days	If less than one day hr.	min.
34	9	15		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Berry
13. Birthplace Md.

MOTHER
14. Maiden Name Celia Nelson
15. Birthplace Md.

16 (a) Informant Annie Berry
(b) Address 1632 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Edwin C. Miller
(b) Address 1000 Eutaw Place

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1946, at 6 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1946, to 2-22 1946
and that I last saw h[illegible] alive on 2-22 1946.

Immediate cause of death Uremia — Duration
Due to Hypertensive Cardio-vascular-renal
Due to disease
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1229 N. Carrollton Ave.

2-23-46

G37790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57E

Registered No. G37790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 Brady Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Brady Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie J. Dinan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Neal Dinan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1872

8. AGE: Years 73 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Thomas Purch
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth O'Brien
15. Birthplace Ireland

16 (a) Informant Mrs. John O'Brien
(b) Address 5310 Brady Ave

17 (a) Burial (b) Date thereof Feb 26, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Weedfield
(b) Address 914 Greenmount Ave

19 (a) FEB 25 1946 (b) [illegible]
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946 at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1946, to Feb 22 1946, and that I last saw h[illegible] alive on Feb 21 1946.

Immediate cause of death Generalized Arteriosclerosis
Coronary Sclerosis

Duration

Due to

Due to

Other Conditions Tumor of the Thoracic-spine
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kurt Levy, Md

Address 230 Forest Place Date signed 2/24/46

VS-150

Dr Kurt Levy Forest Place 230

X

correct age is especially important. Physicians: please write the c[illegible] information asked for carefully and legibly. The the causes of death clearly and legibly supplied.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G37791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E. 23rd St
(c) Hospital or institution: Harry G. Beck
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Lunbridge Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George C. F. Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6351

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23. 1876

8. AGE: Years	Months	Days	If less than one day
69	2	29	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Foreman

FATHER 12. Name Geo. C. F. Montgomery
13. Birthplace Delaware

MOTHER 14. Maiden Name Mary Springer
15. Birthplace Delaware

16 (a) Informant Mrs. Geo. Montgomery
(b) Address 522 Lunbridge Road

17 (a) Burial (b) Date thereof Feb. 26. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b)
(Date rec'd by registrar) (Registrar)

FEB 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946 at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945 to Feb 22 1946 and that I last saw h[illegible] alive on Feb 22 1946.

	Duration
Immediate cause of death Congestive heart failure	5 Days
Due to Cardiovascular renal disease (Chronic Myocarditis)	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry G Beck M. D.
Address 100 E. 23rd St Date signed 2-22-46

G3779½ JL - 39192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (301)

Registered No. G37792

Type or print in ink. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 2 29

(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 116 N. Bond St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1873?

8. AGE: Years	Months	Days	If less than one day
72 ?	10 ?	8 ?	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2-25-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A. A. County

18 (a) Funeral director Burns & Maggie Wright
(b) Address 724 Fremont St

19 (a) FEB 23 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1946, at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1938, to Feb. 20 1946, and that I last saw h im alive on Feb. 20 1946

Immediate cause of death	Duration
Bronchopneumonia	1 wk
Due to Acute intestinal obstruction	1 wk
Due to Ingeunal Hernia	2 yrs
Other Conditions Cardiac arrhythmia (Include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation:

of autopsy: Chronic Pulmonary edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas J. Orwell M. D.

Address Balto City Hospitals signed 2-21-46

VS 150

107

G37793 RAMSEAUR G37793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1250

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Ramseaur

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Ramseur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace Columbia S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Kennedy
13. Birthplace S. C.

MOTHER 14. Maiden Name Minnie Bailey
15. Birthplace S. C.

16 (a) Informant George Ramseur
(b) Address 1306 Harlem Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1946 (month) (day) (year)

(c) Cemetery or crematory Newton D.C.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3929 W. Lombard St.

19 (a) FEB 25 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23, 1946, at 6:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1946, to Feb 23 19, and that I last saw h-r alive on Feb 23 1946.

Immediate cause of death	Duration
Toxemia	
Due to Puerperal peritonitis & Uremic insufficiency	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard O. Kaaw M. D.
Address Univ. Hosp. Date signed 2/25/46

G37794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G37794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Myrtle Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE EMORY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Henry Washington
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Green
15. Birthplace Eastern Shore, Md.

16 (a) Informant Mrs. Blanche Williams
(b) Address 713½ W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory W. Laurel Cem
Location

18 (a) Funeral director Miss Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Hamilton Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1946, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia - right.

Due to

Other Conditions Empyema - right chest.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 2-23-46

G37795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 739 Stirling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rosie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11, 1893

8. AGE: Years 52 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Dan Shaw
13. Birthplace Fayetteville N. C.

MOTHER 14. Maiden Name Flora McGeitype
15. Birthplace Fayetteville N. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb 25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Carrollton St

19 (a) Date rec'd by local Reg. (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1946, at 1.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1946, to Feb. 22 1946, and that I last saw h alive on Feb. 22 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	1½ hours
Due to Hypertension Cardiovascular disease	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Williams M. D.
Address Johns Hopkins Hospital Date signed 2-22-46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G37796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37796 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 E. Chase St.
(c) Hospital or institution: St. Frances Convent
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister M. Annunciata Butler O.S.P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1878

8. AGE: Years 67 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Mechanicsville St Marys County Md. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name John Butler
13. Birthplace St Marys County Md.

MOTHER
14. Maiden Name Louise Cotter
15. Birthplace St. Marys County Md.

16 (a) Informant Mother M. Teresa O.S.P.
(b) Address 501 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Frederick Road

18 (a) Funeral director Mrs. Albert A. Elbert Daughter
(b) Address 1129 W. Baltimore Street

19 (a) FEB 25 1946 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23rd 1946, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946, to Feb 23rd 1946, and that I last saw h[illegible] alive on Feb 21 1946.

	Duration
Immediate cause of death: Coronary thrombosis	1 week
Due to: Arteriosclerosis	1 year
Due to:	
Other Conditions: Hypostatic Pneumonia	1 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. G. Shuttard M. D.
Address 130 N. Charles St. Date signed Feb 27 1946

X X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37797 — BALTIMORE CITY HEALTH DEPARTMENT — G37797 Registered No.

CERTIFICATE OF DEATH 942

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 Northgate Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Alameda Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Henry Hawkens Hawkens

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine E. Reilly
6 (c) If alive, give age 6 0 years

7. Birth date of deceased (mo., day, yr.) 6/24/1882

8. AGE: Years	Months	Days	If less than one day
63	7	28	hr. min.

9. Birthplace Md (Town, county, and State)
10. Usual Occupation Manf Drugs
11. Industry or Business

FATHER 12. Name John T. Hawkens
13. Birthplace Md

MOTHER 14. Maiden Name Mary E. Lamon
15. Birthplace Md

16 (a) Informant Mrs. D. H. Hawkens
(b) Address 3720 Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Otto Hess
(b) Address 3111 Harford Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23-1946, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D. Medical Examiner
Date signed 2-23-46

637798 637798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Respect age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Wheeler Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Wheeler Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME John G. Langgood

3 (b) If veteran, name war ****
3 (c) Social Security Account No. ****

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaretha Langgood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1864

8. AGE: Years 81 | Months 11 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Charles John Langgood
13. Birthplace Germany

MOTHER
14. Maiden Name Dorthea ?
15. Birthplace Germany

16 (a) Informant Mr. G. H. Switzer
(b) Address 110 N. Wheeler Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) 2-26-1946 (Date received by registrar) (b) Wilmington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1946, at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1943 to Feb 1946, and that I last saw him alive on 2/22 1946

Immediate cause of death: Aortic - Sclerotic C. V. D. — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. G. Brund M. D.
Address 3325 Pinkney Ave Date signed 2/25/46

VS 150

G37799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No. G37799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Scott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice A. Fetzer (ALICE CLARA FETZER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Jos. Fetzer
(c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) abt. 1876

8. AGE: Years	Months	Days	If less than one day
abt. 70			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leonidus Tyler
13. Birthplace Md.

MOTHER
14. Maiden Name Teresa Markley
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Boland
(b) Address 2714 Kenley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A A Co. Md

18 (a) Funeral director Jos Joerdens Son
(b) Address 827 Park Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 19 46, at 1130 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Schrink M.D. Medical Examiner.
Date signed 2/26/46

VS 151

Write the causes of death clearly and legibly.

G37800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Charles St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Maurice Talbot Weller

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-8699

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-10-1904

8. AGE: Years	Months	Days	If less than one day
41	3	14	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Shipping Dept.
11. Industry or business Beverage Distributing Co

FATHER
12. Name Charles Clifton Weller
13. Birthplace Thurmont, Md.

MOTHER
14. Maiden Name Kate E. Watts
15. Birthplace Balto. Md.

16 (a) Informant Kate E. Melvin
(b) Address 4736 Vilers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Hgts ave.

19 (a) 2-25-1946 (Date rec'd by registrar) (b) Interment Filed (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an ..... (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....

Coronary occlusion

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Benedict Skitarelic M.D. (Medical Examiner.)
Date signed 2-25-46

G37801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37801 Registered No. 1310

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317. S. Collins ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317. S. Collins ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adaline E. Wellstood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Andrew B. Wellstood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18-1866

8. AGE: Years 79 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Hornell New York (Town, county and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Josiah Ingalls
13. Birthplace New York

MOTHER 14. Maiden Name Mrs. E. Dewey
15. Birthplace New York

16 (a) Informant Leon J. Wellstood
(b) Address 317. S. Collins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-26-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Jeannie Cook Lyser
(b) Address 1400 W. North Ave.

19 (a) (Date rec'd by reg'r) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 23 1946, at 11-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1945 to Feb 24 1946
and that I last saw her alive on Feb 23 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 7 days

Due to: Cardio-Vascular Disease — 2 years

Due to:

Other Conditions: Chronic Nephritis — 2 years
Glomerular
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot M. Johnson M. D.
Address 3432 Munsey Ave. Date signed

G37802 G37802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore North Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. Wallace

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	717-07-7901

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth A. Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1888

8. AGE: Years	Months	Days	If less than one day
57	10	24	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Telegraph Operator
11. Industry or business Penna R.R.

FATHER
12. Name George W. Wallace
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Annan
15. Birthplace Pa.

16 (a) Informant Mrs. Ruth A. Wallace
(b) Address 335 E. North Ave.

17 (a) Burial (b) Date thereof 2/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1946, at 6.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1945 to Feb. 23 1946
and that I last saw him alive on Feb. 23 1946

Immediate cause of death	Duration
12/10/45 - 2/23/46	
Chronic Heart disease.	4 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh Forsythe M. D.
Address 424 E. North Ave Date signed 2/25/46

(over) X

G37803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 G37[illegible] Death No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address B'dway & Fairmount
(c) Hospital or institution:
CHURCH HOME & HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt. Mane
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Elgin Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES C. ROGERS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-56

8. AGE: Years 89 | Months 6 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace VIRGINIA (Nutsville)
(Town, county, and state)

10. Usual Occupation Retired Insurance

11. Industry or business Business

FATHER
12. Name JAMES E. ROGERS
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name Laura Carpenter
15. Birthplace VIRGINIA

16 (a) Informant Robert Rogers
(b) Address 3301 Elgin Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

FEB 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1946 at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1946, to Feb 23 1946, and that I last saw him alive on Feb 23 1946

Immediate cause of death Uremia — Duration: Uremia 27 Days

Due to Urinary retention — Duration: 2 weeks duration

Due to Prostatic Hypertrophy

Other Conditions Bronchopneumonia, Cardiac decompensation grade III
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jean W. Campbell M. D.
Address Clinical Assoc. Path. Date signed Feb 28 1946

X

correct age is especially important. Physicians: please

G37804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G37804 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4213 Kenshaw Ave.
(c) Hospital or institution:
28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4213 Kenshaw Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank O'Donnell

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish & World #1	215-03-7850

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife. Mary nee Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1879

8. AGE: Years	Months	Days	If less than one day
67	1	7	hr. min.

9. Birthplace Wilmington, Delaware (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Goode & Craft

FATHER
12. Name John F. O'Donnell
13. Birthplace Delaware

MOTHER
14. Maiden Name Mamie Zebele
15. Birthplace Delaware

16 (a) Informant Mrs. Mary O'Donnell
(b) Address 4213 Kenshaw Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd. Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna. Aves. Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1946; at 7P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 18 1945 to Feb 22 1946
and that I last saw him alive on Feb 24 1946

Immediate cause of death — Duration
Coronary Thrombosis — Sudden
Due to Chr Myocarditis — 2
Due to Arteriosclerosis — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. E. Nichols M.D.
Address Pikesville 8 Md. Date signed Feb 25 46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37805 — 1225 37809 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2723 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Lee Bennett

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife William E. Bennett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1874

8. AGE: Years	Months	Days	If less than one day
71	3	27	hr. min.

9. Birthplace Parkton, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Sanders
13. Birthplace Virginia

MOTHER
14. Maiden Name Sallie Chilcote
15. Birthplace Virginia

16 (a) Informant Mrs. Frank Sellman
(b) Address 2723 Baker St.

17 (a) Burial (b) Date thereof 2/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 24, 1946, at 6:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 19 to Feb 24 1946.
and that I last saw her alive on Feb 23 1946

Immediate cause of death	Duration
Cerebral thrombosis	1 week
Due to arteriosclerosis	1 year
Due to age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert Mortimer Jr. M.D.
Address 2706 St Paul St Date signed 2/25/46

VS 150

FEB 25 1946

G37806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G37806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4824 Asbury Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4824 Asbury Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA IRNE CLARKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife John Howard Clarke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1877

8. AGE: Years	Months	Days	If less than one day
68	5	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas M. Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Roseanna Telen
15. Birthplace Ireland

16 (a) Informant Mr. Allen Jones - son
(b) Address 3011 McElderry Street

17 (a) Burial (b) Date thereof 2-26-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) FEB 25 1946 Hunter for Williams
(Registered by registrar) Registrar

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH February 23 1946, at 9.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to 2/23 1946 and that I last saw h[illegible] alive on 2/22 1946.

Immediate cause of death	Duration
Ch. Myocarditis -	5 years
Due to Arteriosclerosis	
Ch. Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Harding
Address 4810 Belair Rd Date signed 2/23/46

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 a

Registered No. G37807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Washington Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Marvel - Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-0855

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Hattie Lee Marvel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19-1885

8. AGE: Years	Months	Days	If less than one day
62.	6	3	/ hr. / min.

9. Birthplace Easton - Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles E. Marvel
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ella Porter
15. Birthplace Maryland.

16 (a) Informant Mrs. Hattie Lee Marvel
(b) Address 2807 Washington Blvd.

17 (a) Burial (b) Date thereof Feb. 24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet.
Location Baltimore - Md.

18 (a) Funeral director C. A. Shepherd & Son
(b) Address 1300 Eutaw Place.

19 (a) (Date received by registrar) FEB 25 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1946 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1946 to 2/22 1946 and that I last saw h[illegible] alive on 2/21 1946.

Immediate cause of death	Duration
Coronary occlusion	1 hr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
M. D.
Address 230 Williams Date signed 2/25/46

VS 150

X

correct age is especially important. Physicians: please write th

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37808
CNK-15724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓61

G37803
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22- 2- 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 79- 11- 6-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2777 Alameda Blvd.
(If rural, give location)
(e) Citizen of foreign country? Cho (Yes or No)
If yes, name country

3 (a) FULL NAME William H. or H. Elliott *William H. Elliott*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18-1866

8. AGE: Years	Months	Days	If less than one day
79	11	6	hr. min.

9. Birthplace Maryland Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Glass Blower

FATHER
12. Name James Elliott
13. Birthplace Maryland Balto

MOTHER
14. Maiden Name Mary Essex
15. Birthplace Maryland Balto

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (Month) (day) (year)
(c) Cemetery or crematory St Mathias
Location O'Donnell Street

18 (a) Funeral director George F. Roth Inc
(b) Address 1735 Eastern Ave

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH February 24 1946, at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1946 to Feb. 24 1946 and that I last saw h. im alive on Feb. 24 1946

Immediate cause of death: Diabetes Acidosis — Duration

Due to:

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Rupture of gall bladder
of autopsy Atherosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 5. Calvert Date signed 2-25-46

X

G37809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37809 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave.
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country?

3 (a) FULL NAME John Henry Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Lula
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1885

8. AGE: Years	Months	Days	If less than one day
61		6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Produce Business
11. Industry or business Retired

FATHER
12. Name John Lee
13. Birthplace Maryland

MOTHER
14. Maiden Name ? Wade
15. Birthplace Md

16 (a) Informant Lula Lee
(b) Address 301 S. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27 '46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co.

18 (a) Funeral director Harry A Wright
(b) Address 4101 Edmondson Ave

19 (a) FEB 25 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1946, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18th 1946 to Feb 24 1946, and that I last saw h. im alive on Feb 24th 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary edema	
Due to C.V.D.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Jonyaley
Address Maryland Gen Hospital Date signed M. D. 2/24/46

correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. The ... CAPITAL INK. ... the causes of death clearly and legibly.

VS 150

G378x0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G378x0 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Pumphrey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 W. Lombard St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME G. Virginia Truemmel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widow

6 (b) Name of husband or wife Late May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1875

8. AGE: Years	Months	Days	If less than one day
70	4	21	hr. min.

9. Birthplace Va.

10. Usual Occupation H. W. (Town, county, and state)

11. Industry or business

FATHER
12. Name Amos
13. Birthplace Va.

MOTHER
14. Maiden Name Arnetta Napier
15. Birthplace Va.

16 (a) Informant Mrs. Alma Mahoney
(b) Address 1621 Pumphrey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Elkridge, Md.

18 (a) Funeral director Harry A. Nitzke
(b) Address 410 E Edmondson ave.

19 (a) 1940 (Date rec'd by registrar) (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1946 at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1946 to Feb 23 1946 and that I last saw h[er] alive on Feb 23 1946.

Immediate cause of death
(a) Coronary Thrombosis — Duration 3 days
Due to (b) Arteriosclerotic Cardio Vascular Disease — ?
Due to (c) Hypertensive Cardio Vascular disease — 2 yrs
Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen C. Montaniole
Address 6714 Holabird Ave Date signed M. D. 2/28/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G37811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E G37811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Christian St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Geldmacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1899

8. AGE: Years 47 | Months 0 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry E Schafer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alice Musgrove
15. Birthplace Baltimore

16 (a) Informant Henry M. Geldmacher
(b) Address 1909 Christian St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Henry W Voigt
(b) Address 4101 Edmondson Ave

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1946, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 19 44 to 2/22 1946, and that I last saw h[illegible] alive on 2/22 1946.

Immediate cause of death: Carcinoma of colon — Duration 1 yr.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 8/1/45

Major findings of operation: Carcinoma of colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2030 W. Mulberry Date signed 2/23/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37812 G37812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 S. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hansely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1875

8. AGE: Years	Months	Days	If less than one day
70	7	7	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Balto. Trunk Co.

FATHER
12. Name Andrew Hansely
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary Rotz
15. Birthplace Austria

16 (a) Informant Mrs. Catherine Hansely
(b) Address 403 S. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27/46. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Kitzke
(b) Address 4101 Edmondson Ave.

19 (a) FEB 25 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23- 1946 at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1945 to 2-23- 1946 and that I last saw h[illegible] alive on 2-23- 1946

Immediate cause of death	Duration
Coronary Occlusion	1/2 hr.
Due to Coronary Sclerosis	18 mo.
Due to Generalized Arteriosclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Pittman M. D.
Address 2424 Eastern Ave. Date signed 2-25- 46

Huntington Press

VS 160

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G37813

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 S. Linwood Avenue
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 S. Linwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Kaminski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lawrence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1866

8. AGE: Years 79 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Poznan, Poland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Augustyniak
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Nowicka
15. Birthplace Poland

16 (a) Informant Mrs. Helen Kneval
(b) Address 714 S. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Ave.

19 (a) FEB 25 1946 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946, at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1946, to Feb 22 1946, and that I last saw her alive on Feb 21 1946.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Chr. hypertension	2-16-46
Due to Myocardial Failure	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Schemmel M. D.
Address 342 S. Conkling Date signed 2-23-46

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT IN WHITE PLAINLY, WITH UNFADING INK.

G37814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G37814 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Lemmert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race white

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife J. Henry Lemmert

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) July 5 1883

8. AGE: Years 62 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Carl Spencer
13. Birthplace ?

MOTHER
14. Maiden Name ? Schrick
15. Birthplace ?

16 (a) Informant J. Henry Lemmert
(b) Address 3640 Falls Rd

17 (a) Burial (b) Date thereof Feb 26, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A Fooks
(b) Address Baltimore & Fayette St.

19 (a) FEB 25 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 - 1946, at 6 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-6-1946, to Feb-23-1946, and that I last saw h[illegible] alive on Feb-23-1946.

Immediate cause of death Pulmonary Failure — Duration

Due to Coronary artery disease

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George F. Pettinger M. D.

Address U. M. H. Date signed 2/26/46

Huntington [illegible]

correct age is especially important. Physicians: please write the

G37815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37815
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Balto. 28 Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Smithwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Flanagan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Jeannette J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1864

8. AGE: Years 81 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name John Flanagan
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. Alma E. Lacey
(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Jung & Stanley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1946 at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1946 to 2/24 1946, and that I last saw him alive on 2/24 1946.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Arteriosclerosis	
Due to	
Other Conditions Senility Pneumonia Not Done	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Cliff Routzahn, M.D.
Address 28 Agnes Lane Date signed 2/25/46

correct age is especially important. Physicians: please write the

VS 150

97

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1110 B

Registered No. 637816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Clusterfield Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Steigerwald

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-9124

4. Sex: Male | 5. Color or race: White | 6 (a) Single, Married, Widowed or divorced: Widowed

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-1880

8. AGE: Years 66 | Months 0 | Days 23 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leo. S. Steigerwald

13. Birthplace Ger.

MOTHER 14. Maiden Name Gertrude Kerndt

15. Birthplace Ger

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Samuel Gardens

Location

18 (a) Funeral director Philip Henry Lord

(b) Address 2024 Eutaw St

19 (a) (Date rec'd by registrar) (b) Huntington Wilson Registrar

FEB 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-1946 at 6.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1946 to 2-22 1946 and that I last saw h.... alive on 2-22 1946

Immediate cause of death	Duration
CARDIAC FAILURE AND →	3 YEARS
PULMONARY EDEMA →	2 DAYS
Due to CAUSE UNDETERMINED	
Due to	
Other Conditions PLEURAL EFFUSION, RIGHT	2 MONTHS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy AS ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. P. Asper M.D.

Address Johns Hopkins Hosp Date signed Feb 23 1946 M. D.

G37817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G37817

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S. Light St.
(c) Hospital or institution: South. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret Burns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1886

8. AGE: Years 59 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Patrick Burns
13. Birthplace Balto. Md. Ireland

MOTHER 14. Maiden Name Catherine Hanlon
15. Birthplace Balto. Md

16 (a) Informant Margaret Burns
(b) Address 426 N. Bowling Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St.

19 (a) FEB 27 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25- 1946, at 8:45- M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1946 to 2-25 1946, and that I last saw h[illegible] alive on 2-25- 1946

Immediate cause of death	Duration
Generalized Carcinomatosis	2 mos.
Due to Carcinoma of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hillman Huntington Williams M.D.

Address 2.B.C.A. Date signed 2-25-46

VS 190

Huntington Williams M.D.

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37818 178a (Registered No.) G37818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital DOA.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-9481

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1870

8. AGE: Years 75 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Geo R. Smith
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Hatton
15. Birthplace Baltimore

16 (a) Informant Mrs Washington Smith
(b) Address 412 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/46 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Baltimore

18 (a) Funeral director Philip Henry Funeral
(b) Address 2124 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946, at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-22-46 ? P. M.
(b) Where did injury occur? 1208 Linden Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Open gas burner.

23. Signature Benedict Skaterelic M.D.
Medical Examiner.
Date signed 2-23-46.

VS 151

G37819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √170c

G37819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Rhodale ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Berry

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Emma D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7-1871

8. AGE: Years	Months	Days	If less than one day
74	9	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Millard Berry
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace Md.

16 (a) Informant Earl N. Berry
(b) Address 3302 Rhodale Ave.

17 (a) Burial (b) Date thereof 2/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Springfield
Location Carroll Co. Md.

18 (a) Funeral director Leonard J. Luck
(b) Address 6305 Harford Rd.

19 (a) FEB 25 1946
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25- 19 46 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infarction
of Lung, left, Pulmonary
Embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-28-46 at 10/27 M.
(b) Where did injury occur? 800 Blk. Harford Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by auto.

23. Signature Robert Co Pratten M.D.
Medical Examiner.
Date signed 2-25-46

VS 151

...the causes of death clearly and legibly. ...typewriter; if by physician, please write the c...

637820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 637820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton and Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 Belle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-46

8. AGE: Years | Months | Days | If less than one day: 1 hr. 5 min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER
12. Name Ralph
13. Birthplace Keyser West Va.

MOTHER
14. Maiden Name Kathleen McDonald
15. Birthplace W. Va.

16 (a) Informant
(b) Address

17 (a) 2-46 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Burial

(c) Cemetery or crematory
Location Parsons West Va.

18 (a) Funeral director Rusk Funeral Home
(b) Address 5205 Harford Rd.

19 (a) 2-25-46 (Date rec'd by registrar) (b) Huntington Williams, M. D.

VS 130
FEB 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 19 46 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 19 , to 2/23 19 46 and that I last saw her alive on 2/23 19 46.

Immediate cause of death: Atelectasis — Duration

Due to: Premature birth

Due to: 5½ mo. Pregnancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon D'Elia M. D.
Address St Agnes Hosp Date signed 2/24/46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WRITE FIRMLY, WITH UNFADING INK.

G37821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G37821 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Lantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	divorced

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 7. 1865

8. AGE: Years	Months	Days	If less than one day
70	10	16	hr. 1875 min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Associated Press

FATHER
12. Name Thilhom A Lantz
13. Birthplace Md

MOTHER
14. Maiden Name Amanda Lambert
15. Birthplace Md

16 (a) Informant Mrs Wm C Burrell
(b) Address Cumberland

17 (a) Burial (b) Date thereof 2/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Tilhom Co Inc
(b) Address 1217 E Cont St

19 (a) FEB 25 1946 Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Feb. 23, 1946, at 10:55 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2-24-46.

637822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 11 days
(e) Length of stay in Baltimore (yrs., mos., or days): 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Montgomery
(c) City or town: Gaithersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 16 Diamond Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Stenger, Edward Joseph

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Apr. 19, 1892
8. AGE: Years: 53 | Months: 10 | Days: 4 | If less than one day: hr. min.
9. Birthplace: Orange Valley, NJ (Town, county, and state)
10. Usual Occupation: Field Employee
11. Industry or business: US PHS- NIH-Bethesda, Md.

FATHER
12. Name: Lawrence Stenger
13. Birthplace: France

MOTHER
14. Maiden Name: Louise Meyer
15. Birthplace: France

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof: 2/26/46 (month) (day) (year)
(c) Cemetery or crematory: Lutheran Rotunda
Location: Ft. Meyer Rd.

18 (a) Funeral director: Hudson Funeral Home
(b) Address: 1217 Eutaw St.

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 23 1946, 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1946 to Feb. 23 1946 and that I last saw him alive on Feb. 23 1946.

	Duration
Immediate cause of death: Pneumonia, bronchial, terminal	11 days
#2- Bronchial asthma with	1 yr.
Due to: cardiac hypertrophy	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 2/25/46
US Marine Hospital, Balto, Md.

637863 | BALTIMORE CITY HEALTH DEPARTMENT | 637863 Registered No.

CERTIFICATE OF DEATH

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Serio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1945

8. AGE: Years | Months: 2½ | Days: 12 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Vincent A Serio
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Agnes E Jones
15. Birthplace Baltimore Md

16 (a) Informant Vincent A Serio
(b) Address 1810 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)
(c) Cemetery or crematory Druid Catholic
Location Baltimore Md

18 (a) Funeral director Wilson Lodge
(b) Address 1217 E Pratt St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1946

Waiting for Autopsy

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1946, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 2-24-46.

X

G37854 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G37841

CERTIFICATE OF DEATH

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md- (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Talbot Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Wagner

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1907

8. AGE: Years	Months	Days	If less than one day
38	2	26	hr. min.

9. Birthplace Mountain City Tenn
(Town, county, and state)
10. Usual Occupation Rubber
11. Industry or business Rocky Insulator

FATHER
12. Name David H Wagner
13. Birthplace Penn

MOTHER
14. Maiden Name Margaret B Stout
15. Birthplace Penn

16 (a) Informant Oscar Wagner
(b) Address Frankenville Md

17 (a) Burial (b) Date thereof 2/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Knoll Craig Cem
Location Abingdon Va

18 (a) Funeral director William Cookus
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1946, at 11 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial Hemorrhage.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 24 1946
(b) Where did injury occur? 5212 Talbot Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home - While at work? No
(d) Means of injury Fall down stairs
23. Signature Benedict Skitarelic M.D.
Medical Examiner
Date signed 2-25-46

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

637825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 637825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 E Monument
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 E Monument
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew C. Supicka

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1892

8. AGE: Years 53 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Francis X Supicka
13. Birthplace Bohemia

MOTHER
14. Maiden Name Elizabeth Svec
15. Birthplace Bohemia

16 (a) Informant Frank X Supicka
(b) Address 2226 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md

18 (a) Funeral director Frank Carchidas
(b) Address 900 N Eutaw St

19 (a) (Date rec'd by registrar) FEB 26 1946 (b) Washington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946 at 9:40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1946 to Feb 23 1946 and that I last saw him alive on Feb 22 46

Immediate cause of death: Carcinoma of Prostate — Duration: last 2 years
Due to: Pulmonary Tuberculosis
Due to:
Other Conditions: Arthritis Myocarditis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Purdy M.D.
Address 100 N Eutaw St Date signed 2-26-46

VS 150

G37826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37826 Registered No. 13/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Gibson Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Richardson, John Buchanan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Helen Grady
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1882

8. AGE: Years 64 | Months 0 | Days 16 | If less than one day hr. min.

9. Birthplace Woodville, Miss.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm. Richardson
13. Birthplace Miss.

MOTHER
14. Maiden Name Nonnie ?
15. Birthplace Miss.

16 (a) Informant Records
(b) Address US Marine Hospital,

17 (a) Removal (b) Date thereof 2/28/46
(~~Burial, cremation, or~~ removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Arlington Nat'l. S. National
Location Arlington Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

FEB 26 1946 Arlington Williams, Jr.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946, at 7:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1946, to Feb. 25 1946, and that I last saw him alive on Feb. 25 1946.

	Duration
Immediate cause of death: Hemorrhage cerebral	3 days
Due to: Arteriosclerosis general	Unknown
Due to: Nephrosclerosis with hypertension	Unknown
Due to: Cardiac hypertrophy	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 2/25/46
US Marine Hospital, Balto, Md.

Funeral directors, institutions, and physicians are required by law to report every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G37837

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 E Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 E Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna A Disney

3 (b) If veteran, name war: M
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: /
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1883

8. AGE: Years 64 | Months 0 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Unemployed

FATHER
12. Name Milhorn I Disney
13. Birthplace Md

MOTHER
14. Maiden Name Mary H Pudson
15. Birthplace Md

16 (a) Informant Miss Dorothy Jones
(b) Address 2021 E Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Milhorn Funeral Home
(b) Address 1211 Gay St

19 (a) FEB 26 1946 (Date rec'd by local reg.) (b) Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946 to Feb 24 1946 and that I last saw h[illegible] alive on Feb 24 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days
of the Brain
Due to Bronchial Asthma — 1 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Dunkle
Address 1701 E. Fayette St Date signed Feb 27 1946

VS 150

G37828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G37828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4318 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

1513

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Delamarter

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louis Delamarter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1862

8. AGE: Years 83 | Months 5 | Days 22 23 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Parks
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Norien Delamarter
(b) Address 4318 Reisterstown Road

17 (a) Burial (b) Date thereof 2/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Fa. Aves.

19 (a) FEB 26 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1946, at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1946 to Feb 23 1946 and that I last saw her alive on Feb 23 1946.

Immediate cause of death	Duration
Lobar Pneumonia	6 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 2/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G37829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37829 Registered No. 181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: North Bell Ave. Hosp
(c) Hospital or institution: – 1217 S. Light St

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severn Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crain Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Marie Van Meter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1942

8. AGE: Years 3 | Months 6 7 | Days 5 | If less than one day hr. min.

9. Birthplace Severn, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Abraham Van Meter

13. Birthplace Md

MOTHER 14. Maiden Name Bertha (Van Meter)

15. Birthplace Md.

16 (a) Informant Mr Abraham Van Meter

(b) Address Crain Highway, Myd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Glen Burnie

18 (a) Funeral director John F Clergy Inc

(b) Address 714 Light St.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1946, at 6 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946 to 19 , and that I last saw h[illegible] alive on 2-24 1946.

Immediate cause of death	Duration
Shock due fluid loss	Hrs.
Due to 2nd + 3rd deg. burns of thighs + face (about 50% of body)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2-24-46 at 1[illegible] P.M
(c) Where did injury occur? Severn Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Fire from stove

23. Signature Harold [illegible] Wembley M.D.

Address [illegible] Date signed 2-24-46

VS 150

Dr Benedict Shutzer M.D.

G37830.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G37830

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D: 6:0
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Brington Rd.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles Meekins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1867

8. AGE: Years	Months	Days	If less than one day
78	10	20	.....hr. .....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation Capt on tugboat
11. Industry or business Towing

FATHER
12. Name Samuel Meekins
13. Birthplace Md.

MOTHER
14. Maiden Name Mary V. Hanna
15. Birthplace Md

16 (a) Informant Mrs Ethel V. Knill
(b) Address Woodbine Md.

17 (a) Burial (b) Date thereof 2/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F Henry Inc
(b) Address 711 Light St

19 (a).....(b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

FEB 25 1946 VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1946, at 11:25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Hypertrophy & Dilatation; Myocardial Fibrosis

Due to Generalized Arteriosclerosis

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 25 1946

G37831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G37831

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Morris Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Morris St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE A. JOHNSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1883

8. AGE: Years	Months	Days	If less than one day
62	5	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George A. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Celia ?
15. Birthplace Md.

16 (a) Informant Mrs. Ethel Anderson
(b) Address 1021 Morris Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27,1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral dire Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
Registrar

FEB 26 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1946 at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to 2/25/1946 and that I last saw h alive on 2/25/1946

Immediate cause of death	Duration
Coronary Thrombosis	18 m
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of inj
23. Signature H. Cu Celia M. D.
Address 764 Mosher Date Feb 26 46

10-15-1901

037832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 037832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Reddenhall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Delander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15 1901

8. AGE: Years 44 | Months 5 mos 4 | Days 8 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Delander
(b) Address 807 Reddenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah F. Brown
(b) Address 1021 W Montgomery St

19 (a) FEB 26 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1946, at 9:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema, Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Taylor M.D. Medical Examiner.
Date signed 2-23-46

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37833 ✓ 127B G37833

Print the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 W. Hall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 W. Hall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Reynolds

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation L
11. Industry or business

FATHER
12. Name Sam Reynolds
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Ruth Champ
(b) Address 2 W. Hall St.

17 (a) Burial (b) Date thereof 2/27/41
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Ct
Location Balto City

18 (a) Funeral director Isaiah S. Brown Son
(b) Address 108 N Montgomery St

19 (a) FEB 26 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946, at 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Post operative peritonitis

Due to Operative removal of Gall bladder

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert C. Graham M.D.
Medical Examiner.
Date signed Feb. 23 1946

037834

BALTIMORE CITY HEALTH DEPARTMENT

TN. 74378

CERTIFICATE OF DEATH

97

Registered No. 037834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 8- 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Betz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28th 1865

8. AGE: Years	Months	Days	If less than one day
80	1	15	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Jacob Betz
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Hessian
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (records
(b) Address 4940 Eastern Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 26 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13th 1946, at 1.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1942 to Feb 13 1946 and that I last saw h im alive on Feb 13th 1946

Immediate cause of death
(a) Bronchopneumonia, bilateral — Duration 5 days
Due to (b) Superficial Gangrene of Penis — 6 days
Due to (c) Generalized Arteriosclerosis — 10 yrs.
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rush E. Butterville M. D.
Address Baltimore City Hosp. Date signed Feb 14, 1946

8318

VS 150

G37835

AB-71909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37835

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs. 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 736 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Vessel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Willie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5-1899

8. AGE: Years	Months	Days	If less than one day
46	6	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jim Anderson
13. Birthplace Md.

MOTHER
14. Maiden Name Lee ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 26 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17- 1946 at 8.30 A M P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17- 1942 to 2-17 1946 and that I last saw h er alive on 2-17- 1946

Immediate cause of death Bronchopneumonia — Duration ?

Due to

Due to

Other Conditions H C V D
Rt. hemiparesis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Andrews M. D.
Address B C H Date signed 2-20-46

F 3317 107

S-37836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

637836

Registered No.

HB # 88800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) I ? 17
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs. ?

26

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Twyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widow

6 (b) Name of husband or wife Mary Twyman (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May ? 188?

8. AGE: Years	Months	Days	If less than one day
65 ?	? ?	?	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Simon Twyman (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Virginia

16 (a) Informant Balto. City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 26 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 16, 1946, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1944 to Feb. 16, 1946, and that I last saw him alive on Feb. 16, 1946

Immediate cause of death	Duration
Uraemia	
Due to Nephrosclerosis	
Due to	
Other Conditions A.S.H.D. Cerebral vasc. Accs.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address B C H Date signed 2-20-46

VS 150

6319 X

G37837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G37837

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PERSONS WHO FAIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Marshall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Howell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-46.

8. AGE: Years | Months | Days: 1 | If less than one day: 36 hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert J. Howell
13. Birthplace Va

MOTHER
14. Maiden Name Ida Carey
15. Birthplace Md

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 26 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1946, at 9 03 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1946 to 2/18 1946 and that I last saw h[illegible] alive on 2/18 1946

Immediate cause of death: Prematurity — Duration: 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. A. Anderson M. D.
Address Johns Hopkins Hosp Date signed 2-19-46

3316

VS 150

G37838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G37838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 E. Eager St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md.; (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 E. Eager St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Colbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Separated

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1909

8. AGE: Years	Months	Days	If less than one day
36	3	12	hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Colbert
13. Birthplace Prince George Co. Va

MOTHER
14. Maiden Name Merinia Colbert
15. Birthplace N.C.

16 (a) Informant Charles Colbert
(b) Address 1707 E Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County

18 (a) Funeral director Mitchell & Christhilf
(b) Address 1299 N. Carlton St.

19 (a) FEB 25 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to Feb 22 1946, and that I last saw him alive on Feb 21 1946.

Immediate cause of death Aortic Insufficiency — Duration 3 mos.

Due to

Due to

Other Conditions Nephritis, Hypertension & Generalized Arteriosclerosis — 3 mos

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young, M.D.
Address 1429 E. Monument Date signed 2/25/46

VS 150

037639 BALTIMORE CITY HEALTH DEPARTMENT 037639

CERTIFICATE OF DEATH 184

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.00.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4111 Walrad Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis De Sales Kane

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1934

8. AGE: Years	Months	Days	If less than one day
11	2	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles J. Kane
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret M. Prendergast
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Margaret Claire Kane
(b) Address 4111 Walrad Ave.

17 (a) Burial (b) Date thereof 2/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pulaski Aves. Balto. Md.

19 (a) Filed by registrar FEB 26 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946 at 8:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of head.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 24 1946 M.
(b) Where did injury occur? 4111 Walrad Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot Self

23. Signature Benedict Skotarski M.D.
Medical Examiner.
Date signed 2-25-46.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G37840 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 Wilhelm St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Wilhelm St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William O. Clarke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1895

8. AGE: Years	Months	Days	If less than one day
50	3	27	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph M. Clarke
13. Birthplace Pa.

MOTHER
14. Maiden Name Sophia E. Grobe
15. Birthplace Md

16 (a) Informant Mrs. Fannie Schaefer
(b) Address 1810 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Fredrick Ave.

18 (a) Funeral director Harry A. Kirkpatrick
(b) Address 4101 Edmondson Ave.

19 FEB 26 1946 (Date rec'd by registrar) Interment for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 46, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 45, to Feb 24 19 46
and that I last saw h alive on 2/23/46 19

Immediate cause of death	Duration
Acute Myocardetis	4 days
Due to Hemorrhoids Tears	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallam Williams
Address 402 Edmondson Ave. Date signed 2-24-46

X

Wysocki

G37841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Pontiac Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Pontiac Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wysocki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife Late Lydia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1866

8. AGE: Years	Months	Days	If less than one day
79	9	9	hr. min.

9. Birthplace Austrian
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Franz Wysocki
13. Birthplace Austria

MOTHER 14. Maiden Name —
15. Birthplace Austria

16 (a) Informant John Wysocki Jr
(b) Address 301 Pontiac Ave

17 (a) Burial (b) Date thereof Feb. 26/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Pk
Location 3861 Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4[illegible] Lansdowne Ave.

19 (a) FEB 26 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1946, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Feb. 23 1946 and that I last saw h[illegible] alive on Dec-10 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arterio-Sclerotic Heart Disease	
Due to	
Other Conditions Senile Mental Changes (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Luttin M.D.
M. D.
Address 320 Cathedral Ave Date signed 2-25-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G37842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson St
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 424 N. Fulton St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Lipp

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife George A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7 1916

8. AGE: Years	Months	Days	If less than one day
29	10	18	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Timothy D. Keating
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ellen Aug Land
15. Birthplace

16 (a) Informant George A. Lipp
(b) Address 424 N. Fulton St

17 (a) Burial (b) Date thereof 2/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Old Frederick Rd
18 (a) Funeral director Harry H. D. Lyke
(b) Address 4101 E. Monument Ave
19 (Date received by Registrar) FEB 26 1946 Huntingtown, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1946, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 2/25 1946 and that I last saw h[er] alive on 2/25 1946

Immediate cause of death	Duration
Tuberculous Meningitis	3 wks
Due to Pulmonary Tuberculosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature F. L. Stickel Jr.
Address Bon Secours Hosp. Date signed Mo. 2 Dy. 3/46.

VS 150

correct age is especially important. Physicians: please write the

637843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered 637843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin D. Roy 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 W Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Lawson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	M

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/1898

8. AGE: Years	Months	Days	If less than one day
47	1	3	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER 12. Name James Lawson
13. Birthplace Va.

MOTHER 14. Maiden Name Elizabeth Carrington
15. Birthplace Va.

16 (a) Informant Elizabeth Lawson
(b) Address 1537 S. Opal St.

17 (a) Burial (b) Date thereof 2/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. D. Kehoe
(b) Address 4303 Presstman St.

19 (a) 2-27-46 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1946 at M

21. I certify that I took charge of the remains described above, held an Insp. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.
Date signed 2-24-46

X

G37844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Pressteman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Pressteman (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Missouri J. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	W

6 (b) Name of husband or wife Chas. H. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1887

8. AGE: Years	Months	Days	If less than one day
58	7	6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Beautician
11. Industry or business

FATHER
12. Name Richard Reynolds
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Carter
15. Birthplace Va.

16 (a) Informant Pauline Curry
(b) Address 1315 Pressteman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)
(c) Cemetery or crematory Lillian Va
Location Lillian Va

18 (a) Funeral director Leg H. Kelson
(b) Address 1363 Pressteman St

19 (a) (b) Registrar

FEB 28 1946 Huntington Wilkins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24- 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8- 1946 to 2-24- 1946, and that I last saw h-- alive on 2-24- 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Hypertensive Heart. — 6 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Biggs
Address 1516 N. Mount St Date signed 3-5-46

X

No. G37845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G37845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 CLARKSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 CLARKSON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY. M. HOFFMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM. | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY. 2ND 1871

8. AGE: Years 74 | Months 9 | Days 33 | If less than one day hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation HOUSE WORK.

11. Industry or business AT HOME

FATHER
12. Name GEORGE HOFFMAN
13. Birthplace GERMANY.

MOTHER
14. Maiden Name MARG'T. HETRICK
15. Birthplace GERMANY

16 (a) Informant JOSEPHINE HOFFMAN
(b) Address 1605 CLARKSON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 27-46 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A.A.Co.

18 (a) Funeral director Bernard C. Hartle
(b) Address 121 E West St

19 (d) FEB 26 1946 (Date rec'd by reg.) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946 at 9 33 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1945 to Feb 25 1946 and that I last saw h er alive on Feb. 25 1946.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Cardiac Hypertrophy	
Due to Cardiac Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M. Messina
Address 1408 S. Chester St. Date signed 2/25/46

VS 150

X

G37846
FL - 99455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 6

Registered No. G37846

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8hr. 25m
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DEATH:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Edward Fludd

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1941

8. AGE: Years	Months	Days	If less than one day
4	5 7	21	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward
13. Birthplace N. C.

MOTHER
14. Maiden Name Irene Johnson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27, '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
Address 1946 W. Schroeder St.
FEB 26 1946
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25, 1946, at 1:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22, 1946 to Feb. 23 1946, and that I last saw him alive on Feb. 23 1946.

Immediate cause of death	Duration
Fulminating meningococcemia	16 hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard A. Soper M. D.
Address Balto. City Hosp. Date signed 2-27-46

VS 150

X

G37847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G37847 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Buck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-19-1888

8. AGE: Years	Months	Days	If less than one day
57	11	1	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Buck
13. Birthplace Va

MOTHER 14. Maiden Name Sarah Dr. ?
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27 1946 (month) (day) (year)
(c) Cemetery or crematory National Cem. Location Balto. Md.

18 (a) Funeral director Mrs. R. R. Williams
(b) Address 322 N. Schroeder St.

FEB 26 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1946 at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1946 to Feb 20 1946 and that I last saw h[illegible]live on Feb 20 1946

Immediate cause of death: Carcinoma generalized in lungs and liver — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr Abbe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams
Address Johns Hopkins Hosp Date signed 2-24-46 D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C37848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. C37848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 840 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1922

8. AGE: Years 23 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Boyd Wilson
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Ada Parker
15. Birthplace Balto. Md.

16 (a) Informant Ada Wilson
(b) Address 834 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3221 Schroeder St

19 (a) FEB 26 1946 (b) Huntington Williams, M.D.
(Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to Feb 21 1946 and that I last saw h. alive on Feb 20 1946.

Immediate cause of death Tuberculosis (Pulmonary) — Duration 2 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas S Julian Jr M.D.
Address 5171 N. Schroeder Date signed 2/26/46
M. D.

G37849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G37849

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 No Parrish St E.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 No Parrish St E
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hull

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	B.	—

6 (b) Name of ~~husband~~ Mother or wife Helena C. Hull

6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Feb. 21 - 1946

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Alexander Hull
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Helena Lillian Carmick
15. Birthplace Baltimore Md.

16 (a) Informant Helena C. Hull
(b) Address 511 No Parrish St E.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) Date received FEB 26 1946 (b) Huntington Williams, M.D.

VE 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 22 Feb 1946.

Immediate cause of death	Duration
Prematurity	
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Jorgensen M. D.
Address Univ Hosp Date signed 22 Feb 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37850 G37850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 940 W Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 W Saratoga St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Milas W Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-1953

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Mt. Pleasant, N.C.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Lawson Jones
13. Birthplace Mt. Pleasant N.C.

MOTHER
14. Maiden Name Jane Ella Barnes
15. Birthplace Mt. Pleasant, N.C.

16 (a) Informant Bessie Carter
(b) Address 940 W Saratoga St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Feb 26 46 (month) (day) (year)

(c) Cemetery or crematory
Location Concord N C

18 (a) Funeral director Mrs Katie R Williams
(b) Address 2229 Lakewood Ave

19 (a) FEB 26 1946 (Date rec'd by registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1946 at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1946 to 2/24 1946 and that I last saw h alive on 2/23 1946

Immediate cause of death Carcinoma of liver and stomach — Duration 7

Due to

Due to

Other Conditions Arteriosclerosis Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Wallis Sherrington M. D.

Address 701 N Caren Date signed 2/26/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

VS 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Reg. G37851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If so, name country

3 (a) FULL NAME Abraham I Shohan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Flora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 58 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (town, county and state)

10. Usual Occupation teacher

11. Industry or business

FATHER
12. Name Samuel Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Chasy Lea
15. Birthplace Russia

16 (a) Informant Flora Shohan
(b) Address 2220 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-46 (month) (day) (year)
(c) Cemetery or crematory Mekhon Israel
Location Northern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1869 E Balto St

19 (a) (Date received by Registrar) (b) FEB 26 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26- 1946, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Feb. 26 1946, and that I last saw him alive on Feb 27 1946:

	Duration
Immediate cause of death: angina pectoris	6 yrs
Due to: hypertension	8 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Hollander M. D.
Address 1770 Eutaw Pl Date signed 2/27/46

637852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

637852 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 E Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 E Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Edmund~~ Kendall

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-5218

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary P.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 20 1905
8. AGE: Years 40 | Months 2 | Days 4 | If less than one day hr. min.
9. Birthplace Rock Hall Kent Co Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Radio

FATHER
12. Name Joseph H. Kendall
13. Birthplace Md

MOTHER
14. Maiden Name Hanie Greenwood
15. Birthplace Md

16 (a) Informant Mary P. Kendall
(b) Address 329 E Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)
(c) Cemetery or crematory Woo. Cath
Location Old Frederick Rd

18 (a) Funeral director John C Moran
(b) Address 3800 E Baltimore St

19 (a) (Date rec'd by Registrar) (b) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1946 at M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-1945 to 2-24-1946, and that I last saw him alive on 2-22-1946
Immediate cause of death Coronary Thrombosis — Duration Sudden
Due to Hypertension cardiac disease — Duration Unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo. B. Egbert M. D.
Address 280 N. Hartford Rd Date signed 2-25-46

WARNING: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150 (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G37853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 98

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Rochester Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Elliott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 24, 1848

8. AGE: Years 98 | Months 0 | Days 1 | If less than one day — hr. — min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business 0

FATHER
12. Name Peter Rieker
13. Birthplace Germany

MOTHER
14. Maiden Name Miss Hauler
15. Birthplace Germany

16 (a) Informant Mrs. Mary Reity
(b) Address 322 S Kenyon Bye Bells

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location O'Donnell Rd.

18 (a) Funeral director John A. Hogan
(b) Address 3600 E. Baltimore

19 (a) (b)
(Date received by Registrar) (Registrar)

FEB 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1946 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from February 23 1946, to February 25, 1946, and that I last saw her alive on February 25, 1946

Immediate cause of death	Duration
Arteri-sclerotic Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K S Doty M. D.
Address Church Home & Hosp Date signed 2.25.46

Hunting for Relatives

X

G37854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G37854 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 DUNBARTON (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME KATHRYN FINN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife WM. J. FINN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 - 1887

8. AGE: Years	Months	Days	If less than one day
58	4	21	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Wm J EGAN
13. Birthplace ENGLAND

MOTHER
14. Maiden Name BESSIE KELLY
15. Birthplace MD

16 (a) Informant Wm J. Finn
(b) Address 636 Dunbarton Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John E Moran
(b) Address 5000 E Baltimore St

FEB 26 1946

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1946 at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1946 to 2/23 1946, and that I last saw her alive on 2/23 1946

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Acute Cardiac Dilatation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-13-46
Major findings of operation: Chronic Cholecystitis & Cholelithiasis
of autopsy: ?

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A McFadden M. D.
Address St Agnes Hosp. Date signed 2-24-46

VS 150

Huntington Williams, M.D.

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37855 ✓ G37855 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 626 N Robinson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. O

6 (b) Name of husband or wife Millard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1881

8. AGE: Years 64 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Paul Goldsworthy

13. Birthplace England

MOTHER 14. Maiden Name M. Crosgrove

15. Birthplace Hoffman Md

16 (a) Informant Millard Callahan

(b) Address 626 N Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Monumental Road

18 (a) Funeral director John G Moran

(b) Address 3000 E Baltimore St

19 (a) Date received 2/26 1946 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Feby 1946 at 11.40 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Arteriosclerotic Cardio-Vascular Disease

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William G Kelsch M.D. (Medical Examiner)

Date signed 27 Feby 46

93D

G37856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G37856 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... Dist
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17½ S. Castle St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Edward Beck

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife CLARA BECK
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APR. 7 1900

8. AGE: Years	Months	Days	If less than one day
45	10	16	..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation CHAUFFER
11. Industry or business BALTO. CITY

FATHER
12. Name MICHAEL BECK
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ADA BUNCH
15. Birthplace BALTO. MD.

16 (a) Informant CLARA BECK (WIFE)
(b) Address 17½ S. CASTLE ST.

17 (a) BURIAL (b) Date thereof FEB. 27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Gieleurse
(b) Address 403 S. WOLFE ST.

19 (a) ..... (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

FEB 26 1946

VS 15F

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1946, at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature C. J. Schrinka M.D.
Medical Examiner.
Date signed 2/27/46

G37857 G37857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Schoen

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: UNKNOWN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 3 1861

8. AGE: Years 84 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ?

16 (a) Informant ANNA ZEILER (FRIEND)
(b) Address 226 S. WOLFE ST.

17 (a) BURIAL (b) Date thereof FEB. 27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BLAIR ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

FEB 26 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1946, at M

21. I certify that I took charge of the remains described above, held an Autopsy - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2-26-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1330

Registered No. G37858

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5410 PEMBROKE AVE.
(c) Hospital or institution St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5410 Pembroke Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myron Lennon.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 12 1901

8. AGE: Years 44 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Transit Co.

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name EMMA TONY
15. Birthplace MICH.

16 (a) Informant PAULINE LENNON (WIFE)
(b) Address 5410 PEMBROKE AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 28/46 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

FEB 26 1946 (Entered by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/0 1945 to 2/25 1946, and that I last saw h[illegible] alive on 2/25 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Postoperative shock	
Due to Hemorrhage	
Other Conditions — Pyo-hydronephrosis	

(Include pregnancy within 3 months of death)
Date of operation 2/25/46
Major findings of operation: Pyo — hydronephrosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley, M.D.
Address 1405 N. Carrollee Date signed 2/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

637859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

637859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hopkins Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hopkins Apts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine H. Stinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Edward Stinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years: about 75 | Months | Days | If less than one day: hr. min.

9. Birthplace: Phila., Pa. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Sellers Hoffman
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Rose ?
15. Birthplace: Pa.

16 (a) Informant: Mr. Robert Stinson
(b) Address: 809 W. Lake Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: John O. Mitchell's Sons, Inc.
(b) Address: 1900 Eutaw Place
Hunter for Williams

FEB 26 1946 (Date received by Registrar) (b) A Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1946, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 46, to Feb 25 1946, and that I last saw her alive on Feb 24 1946.

Immediate cause of death: Cardiac failure — Duration: 1 yr

Due to: Arteriosclerotic Heart Disease — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Franklin E. Leslie M. D.
Address 1115 St. Paul St. Date signed 2/25/46

Dr. Leslie X

VS 150

G37860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

G37860 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Max Dencin driver

3 (b) If veteran, name war: WW II
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife: Alma Snyder

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 5 1910

8. AGE: Years: 35 | Months: 11 | Days: 8 20 | If less than one day: hr. min.

9. Birthplace: Martinsburg W Va. (Town, county and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles L. Dencindiver
13. Birthplace: Berkley Co

MOTHER
14. Maiden Name: Ella Rose Foulkes
15. Birthplace: Berkley Co W Va

16 (a) Informant: Paige M Dencindiver
(b) Address: Cumberland Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory: Elmwood
Location: Shepherdstown W Va

18 (a) Funeral director: L. D. Byington & Sons
(b) Address: Ellicott City Md

19 (a) FEB 26 1946 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25 1946 at 12:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to carbon monoxide

(a)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: Feb. 25 1946
(b) Where did injury occur? 1305 S. Gilmor St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No Info Available
(d) Means of injury: Asphyxiation due to gas

23. Signature: Roberts Lee Graham M.D. Medical Examiner.
Date signed 2-25-46

G37861

BALTIMORE CITY HEALTH DEPARTMENT X G37861

CERTIFICATE OF DEATH 1048

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE STS.
(c) Hospital or institution:
UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PENNA. (b) County YORK
(c) City or town HANOVER
(If outside city or town limits, write RURAL and give town)
(d) Street No. SECOND AVENUE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY K. WEAVER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 26, 1926

8. AGE: Years	Months	Days	If less than one day
19	10	0	hr. min.

9. Birthplace HANOVER, PENNA.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ROSWELL WEAVER
13. Birthplace HANOVER, PA.

MOTHER
14. Maiden Name KATHERN FRY WEAVER
15. Birthplace HANOVER, PA.

16 (a) Informant ROSWELL WEAVER
(b) Address HANOVER, PA.

17 (a) REMOVAL (b) Date thereof FEB. 26, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. JOSEPH'S
Location HANOVER, PA.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

(a) 26 1946 (Signature and title of registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1946, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1946 to 2/26 1946 and that I last saw her alive on 2/25 1946

Immediate cause of death	Duration
Increased Intra Cranial Pressure	
Due to Meningitis and Brain Abscess - Left Frontal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/23/46
Major findings of operation: Brain Abscess Left Frontal
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H Dennis M.D.
Address University Hospital Date signed 2/26/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The color of eyes and age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37852 — Dr Morris Green — Registered No. [illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3013 Evergreen Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Evergreen Ave
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Bartlett

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Charles F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13. 1884

8. AGE: Years	Months	Days	If less than one day
61	2	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER — 12. Name John F Wiseman
13. Birthplace Ga

MOTHER — 14. Maiden Name Mary Burk
15. Birthplace Unknown

16 (a) Informant Charles F Bartlett
(b) Address 3013 Evergreen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son Inc
(b) Address 1211 E Fayette St

19 (a) [illegible] (b) [illegible]
(Signature of registrar) Registrar

FEB 26 1946
VS 150
Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 18 1946 to Feby 25 1946 and that I last saw her alive on Feby 22 1946

Immediate cause of death: Acute Cardiac Dilatation — Duration: Feby 25 1946
Due to:
Due to:
Other Conditions: Chronic Myocarditis — Duration: about 7 years
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave Baltimore 14 Maryland Date signed 2/26/46

G37863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

G37863 Registered No.

Please answer all questions in full. Use extra sheet if necessary. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hosp. D.O.A. ward
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3535 Fyndale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson DREBING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna (nee Prell)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1910

8. AGE: Years: 36 | Months: - | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business: Bethlehem Ship Yards

FATHER
12. Name: Louis E. Drebing
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Grace Kratz
15. Birthplace: Baltimore, Md.

16 (a) Informant: Charles A. Drebing
(b) Address: 2837 Beryl Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/1/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto. Md.

18 (a) Funeral director: Charles E. Schmunck
(b) Address: 2601-03 E. Madison Street

19 (a) FEB 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946, at 2 30 AM

21. I certify that I took charge of the remains described above, held an Insp. thereon and from the evidence obtained Autopsy, Inspection or Inquiry.
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-26 at 2 30 AM.
(b) Where did injury occur? 3535 Fyndale Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Self hanging — rope.

23. Signature Benedict Shatarelie M.D. Medical Examiner.
Date signed 2-26-46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Elmtree St. Curtis Bay.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Elmtree St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Stalmann

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-2389

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1898

8. AGE: Years	Months	Days	If less than one day
48 yrs.	-	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Raska
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Dvorak
15. Birthplace Czechoslovakia

16 (a) Informant Marie J. Bachman (daughter)
(b) Address 1504 Elmtree St. Curtis Bay.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

FEB 26 1946

VS 10M

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1946 to 2/23 1946, and that I last saw h[illegible] alive on 2/23 1946.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: hypertensive cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 342 Patapsco Ave Date signed 2/26/46

Pvt. F.C. J. Zubrucki, by stamped signature, res. D.

G37865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G37865 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 S. Decker Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Maiorana

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~Living~~ late Salvatore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1878

8. AGE: Years	Months	Days	If less than one day
67	8	12	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business home

FATHER
12. Name Giuseppe Lombardo
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela Santoro
15. Birthplace Italy

16 (a) Informant Sara D'Amario (Daughter)
(b) Address 523 S. Decker Ave

17 (a) Burial (b) Date thereof Feb. 27 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 15e FEB 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946, at 7:12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to Feb. 23 1946, and that I last saw h-r alive on Feb. 23 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank V. Manieri M. D.
Address 333 S. Conkling Date signed 2/25/46

Remington Typewriter Co.

Frank V. Manieri X

G37866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G37866 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 S Monroe Street
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 S. Monroe St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Henry Schubert

3 (b) If veteran, name war None
3 (c) Social Security Account No. 705-09-4308

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Maggie B. Schubert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1880

8. AGE: Years	Months	Days	If less than one day
65	10	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business B & O Railroad

FATHER 12. Name John Schubert
13. Birthplace Maryland

MOTHER 14. Maiden Name Ann Utz
15. Birthplace Germany

16 (a) Informant: Margaret Marie Schubert
(b) Address 3 N. S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director Geo. L. Schubert
(b) Address 201 Frederick Avenue

19 FEB 26 1946 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1946, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Feb 25 1946, and that I last saw him alive on 2-25-46.

Immediate cause of death Coronary Thrombosis & Myocardial Infarction
Due to Arteriosclerosis.
Due to
Other Conditions Chronic Asthma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
5 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. V. Rangle
Address 642 W. 36th St. Date signed 2-25-46

R. V. Rangle X

G37867

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G37867

CERTIFICATE OF DEATH √83a

Reg. Dist. No. _____

1. PLACE OF DEATH:

County _____

City or town 3322 Piedmont ave Balto Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Mo

Hospital, institution, or street address where death occurred: _____ 15

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County _____

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3322 Piedmont Ave

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME Charles M. Stephens

3.(b) Social Security Number _____

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

(b) Name of husband or wife Ruth Kuhn Stephens

6.(c) If alive, give age: 60 years

Birth date of deceased (mo., day, yr.) June 30 1883

7. AGE: Years 62 | Months 7 | Days 26 | If less than one day: ____ hrs. ____ min.

8. Birthplace Columbia, Pa.

(Town, county, and state)

9. Usual occupation Physician.

10. Industry or business _____

11. Name Joshua Stephens

12. Birthplace York Co. Pa.

13. Maiden name Margaret A. McKinley

14. Birthplace York Co Pa

15. Informant Ruth K Stephens

16. Address 3322 Piedmont Ave Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof _____ (month) (day) (year)

Cemetery or crematory Salem Cem.

Location Delta, Pa.

18. Funeral director Hubert P. Harkins

Address Delta, Pa.

19. 26 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1946, to Feb. 25 1946

and that I last saw h. alive on Feb. 24-46 1946

Immediate cause of death _____ DURATION

Cerebral Apoplexy 10 Days

Due to Arteriosclerosis — Some yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE W. Brennan Stood M. D. or other

Address 2200 Parrish Blvd Date signed 2-26-46

G37868 G37868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Payson & Dudeland
(c) Hospital or institution JBGH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Roy K Klingler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 Feb 46

8. AGE: Years	Months	Days	If less than one day
		1	6 hr. 5 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name William Klingler
13. Birthplace —

MOTHER
14. Maiden Name Violet Klingler
15. Birthplace New York

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location
18 (a) Funeral director Johns Hopkins Medical School FEB 26 1946
(b) Address Commissioner of Health
19 FEB 27 1946 Huntington Williams M.D.
(Date rec'd by registrar)

5322

VS.150

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 February 1946, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Feb 1946 to 24 Feb 1946, and that I last saw h/ alive on 24 Feb 1946

Immediate cause of death	Duration
Anoxia	
Due to Icterus Gravis	
Due to Ery Throblastosis Foetalis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leslie A Shaub M.D.
Address JBGH Date signed 2/24

637869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

Registered No. 637869

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 N. Caroline
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	C	widowed

6 (b) Name of husband or wife. ~~Annie~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-11-1880

8. AGE: Years	Months	Days	If less than one day
65	2	15	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Blake
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elijah Johnson
15. Birthplace Baltimore Md

16 (a) Informant Myrtle Dennis
(b) Address 920 N. Caroline St

17 (a) Burial (b) Date thereof 3-1-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County

18 (a) Funeral director Fritz Sons
(b) Address 1408 Eastern Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 27 1946

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1946, at 7 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 2/26 1946 and that I last saw h. alive on 2/25 1946

Immediate cause of death	Duration
Carcinoma - pancreas	unk.
Due to	
Due to	
Other Conditions hypertensive cardio-renal disease (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.

Address 1500 E. Madison St Date signed 2/26/46

Rayner Browne

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

Registered No. G37870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Valley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen R. Courtney

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1874

8. AGE: Years	Months	Days	If less than one day
71	9	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at Home

FATHER
12. Name Edward A. Courtney
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Hobaan
15. Birthplace Ireland

16 (a) Informant Miss Julia C McKevitt
(b) Address 1011 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edgar W. Gaskins & Son
(b) Address 924 E. Eager St.

19 (a) (Signature of local registrar) (b) FEB 27 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25, 1946, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1945 to 2/25 1946 and that I last saw h[illegible] alive on 2/24 1946

Immediate cause of death: Acute Cerebral Hemorrhage — Duration
Due to Ch. Arteriosclerosis
Due to Ch. Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. H. Wohnstein M. D.
Address 733 Arsenal St. Date signed 2/27/46

X

G37871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G37871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 S. Belnord Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 S. Belnord Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Gotkiakamienski (Kamienska)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/1879

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Canning
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Helen J. Kaminski
(b) Address 935 S. Belnord Ave
17 (a) Burial (b) Date thereof 2/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Hamilton
Location Dundalk Md.
18 (a) Funeral director Stephen J. Burkhardt
(b) Address 1000 S. Kenwood Ave
19 (a) (b)
(Date rec'd by registrar) (Registrar)

VS FEB 27 1946 Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1946, at 9:22 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1946 to Feb 26 1946
and that I last saw he alive on Feb 25 1946

Immediate cause of death	Duration
(a) Cardio-respiratory failure	48 hrs
Due to (b) Acute Bronchio-Pneumonia	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry J. Berenzweig M. D.
Address 1000 S. Kenwood Ave Date signed 2/26/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37872 1312 G37872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 W. Pratt St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward Trostle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov 15th 1880

8. AGE: Years	Months	Days	If less than one day
65 65	3	10	.....hr. .....min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Glass blower
11. Industry or business

FATHER
12. Name Eliza Trostle
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs Sarah E. Cooke
(b) Address 306 S. Franklintown Rd

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2930 Frederick Rd

18 (a) Funeral director John Cowan & Son
(b) Address 901-03 E Hollins St.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D.

FEB 27 1946

VS 15M

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946, at 10:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Arteriosclerosis

Other Conditions Emphysema of arteriosclerosis Chronic Nephritis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 2-26-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G37873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37873 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 W Lombard St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary L. Sweeney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: late Alexander
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 2, 1862
8. AGE: Years 83. Months 9 Days 22. If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name John Siebring
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. John Sweeney
(b) Address Route 9 Box 432 Brooklyn Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 11 / 46. (month) (day) (year)
(c) Cemetery or crematory Baltimore Town. Location North Gay st.
18 (a) Funeral director Edw. C. Cowan & Son
(b) Address 901-03 Hollins St.
19 (a) (Date rec'd by registrar) (b) Thurlington Williams, Registrar

FEB 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946, at 10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1946 to Feb 24 1946 and that I last saw h[illegible] alive on Feb 24 1946

Immediate cause of death Chronic Myocarditis and Myocardial degeneration — Duration 2 months
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —
23. Signature John O. Ulrich Jr
Address 122 W. Washington Blvd Date signed 2/26/46 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37874 — BALTIMORE CITY HEALTH DEPARTMENT — G37874

CERTIFICATE OF DEATH

13.B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 E.Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 E.Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles F.Gutridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Loretta M.Trainor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.16,1888

8. AGE: Years	Months	Days	If less than one day
57	4	9	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Empire Cons.Co.

FATHER
12. Name Robert Gutridge
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Gutridge
15. Birthplace Va.

16 (a) Informant Loretta M.Gutridge
(b) Address 1605 E.Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Edmondson Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 (a) Date received by registrar FEB 27 1946 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1946 to Feb 25 1946 and that I last saw him alive on Feb 25 1946.

Immediate cause of death	Duration
Pulmonary + Laryngeal Tuber	7 -
Due to tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Hyde M.D.
Address 1100 E Madison Date signed 2/26/46

G37875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a G37875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 442 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 442 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Balthasar Heige (Hagey)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Elizabeth Stauch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1860

8. AGE: Years	Months	Days	If less than one day
85	3	30	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Philip
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Mrs. Howard Bates
(b) Address 442 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 N. Broadway

19 (a) FEB 27 1946 (Date received by Registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 23 1946, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 JAN. 1946, to 23 FEB 1946, and that I last saw HIM alive on 22 FEB 1946.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	4 DYS.
Due to ARTERIOSCLEROSIS GENERALIZED	10 YRS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Highstein M.D.
Address 121 S. Highland Date signed 2/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1113

G37876 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lanvale Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4016-Eldorado Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Janet-D-Koogle

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Infant
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1945

8. AGE: Years — | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles F. Koogle
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Ruth Melvin
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles F. Koogle
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. H. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md.

VS FEB 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1946 at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1946 to 2/25 1946 and that I last saw her alive on 2/25 1946.

Immediate cause of death Cardio-respiratory failure
Due to Septicemia
Due to
Other Conditions Mediastinal emphysema (Include pregnancy within 3 months of death)

Duration

over

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. F. Roeser
Address Mercy Hosp. Date signed 2/25/46 M.D.

X

G37877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1946

G37877 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Edison Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman D Sheeler

3 (b) If veteran, name war W.

3 (c) Social Security Account No. 577-09-9801

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Lillian M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1898

8. AGE: Years 48 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Superintendent

11. Industry or business Western Electric

FATHER 12. Name George Sheeler

13. Birthplace Balto

MOTHER 14. Maiden Name Mary Dieter

15. Birthplace N.Y.

16 (a) Informant Lillian M Sheeler

(b) Address 1204 Edison Hghy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)

(c) Cemetery or crematory Modena Park

Location Baltimore Co Md

18 (a) Funeral director Wilhelm Son Inc

(b) Address 1217 E Pratt St

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

FEB 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Feby 1946 at 3 15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William R Wolfrath M.D.
Medical Examiner

Date signed 24 Feby 46

G37878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

Registered No. G37878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Chesapeake St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Chesapeake
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1888

8. AGE: Years 57 58 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Weldon N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lawrence Peoples
13. Birthplace N. C

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Roland Edenberg
(b) Address 614 N Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co - Md

18 (a) Funeral director Isaiah L. Brown
(b) Address 1019 W Montgomery St

19 (a) Filed FEB 27 1946 (b) Registrar Millicent Millicent M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946, at 1 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rio death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Forster M.D.
Medical Examiner.
Date signed 2-26-46

VS 151

correct age is especially important. Physicians: please write the c
the causes of death clearly and legibly.

G37879

G37879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 1510
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3915 Liberty Heights ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maurice Herman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-4528

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 10 1874

8. AGE: Years 71 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Jacob Herman
13. Birthplace: Austria

MOTHER
14. Maiden Name: Mollie Handler
15. Birthplace: Austria

16 (a) Informant: Melvin Herman
(b) Address: 3915 Liberty Heights ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28/46 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: 3600 E. Baltimore st

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-26 W. North ave

Date received by Registrar: FEB 27 1946

Registrar: Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946 at 2.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946 to 2-24 1946, and that I last saw him alive on 2-24 1946.

Immediate cause of death	Duration
Hyp Art Scl. Heart Dis. (H.C.V.D.& A.S.H.D.) Con Selerosis	3-5 yrs.
Due to Pulmon edema	1 week
Due to Cellulitis of Legs	?
Due to Arteriosclerosis of Kidneys	

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Arnold Patz M. D.
Address: Sinai Hosp Balt. Date signed 2-26

G37880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G37880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6212 Tramore Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence Earl Meisner

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1941

8. AGE: Years 4 | Months 6 7 | Days 2 3 | If less than one day — hr. — min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm. C Meisner
13. Birthplace Penn.

MOTHER
14. Maiden Name Mary Elizabeth Bauer
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs. M. Elizabeth Meisner
(b) Address 6212 Tramore Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18 (a) Funeral director R. Madison Mitchell
(b) Address Havre de Grace, Md.

19 (a) (Date rec'd by reg.) (b) (Signature) Huntington Williams M.D.

FEB 27 1946 VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946 at 4:40 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd and 3rd degree burns involving 60% Of body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/6
(a) Date of injury February 26, 1946 M.
(b) Where did injury occur? outside 6212 Tramore Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Clothes caught and burned

23. Signature Benedict Shibelski M.D. Medical Examiner.
Date signed 2-27-46

correct age is especially important. Physicians: please write the c

G37881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G37881 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Allendale Road
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Allendale Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth B. Harryman

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife GEORGE HARRYMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/73

8. AGE: Years	Months	Days	If less than one day
72	6 5	17	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Brooks
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Barnes
15. Birthplace Baltimore

16 (a) Informant Son
(b) Address 2901 Allendale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cockeysville Md
Location Texas Cockeysville County

18 (a) Funeral director John C. Hutchins Sons
(b) Address 19 E. Eutaw Place

19 (a) FEB 27 1936 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946 at 9 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1946 to Feb 25 1946 and that I last saw her alive on Feb 25 1946

Immediate cause of death Cardiac Failure — Duration one hour

Due to Coronary Occlusion

Due to Arteriosclerotic Cardiovascular disease

Other Conditions Cerebro Vascular accident

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno W Campbell M. D.
Address Church Home + Hosp Date signed 2/26/46

2 Cafz
G37882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94 G37882 Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 945 No. Chapel St.
(c) Hospital or institution:
9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
9
(d) Street No. 1759 Preston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pollie Marshall

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Julius Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1873

8. AGE: Years 72 Months 4 3 Days 9 15 If less than one day hr. min.

9. Birthplace Wadesboro N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Richard Bennett

13. Birthplace Wadesboro N.C

MOTHER 14. Maiden Name Tama McCormick

15. Birthplace Wadesboro. N.C.

16 (a) Informant Clara Anthony

(b) Address 1006 No. Gay St.

17 (a) Burial (b) Date thereof 2/28/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Ed. Co. Md.

18 (a) Funeral director Robert K. Williams

(b) Address 1515 McElderry St.

19 (a) (Date rec'd by Registrar) Registrar

Washington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1946 to 2/25 1946, and that I last saw h[illegible] alive on 2/25 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lighton M. D.

Address 501 Cherry Hill Rd Date signed 2/25/46

VS 150

G37883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G37883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.D. and give town)
(d) Street No. 1916 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Mary NEARY.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-0455

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bridget

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Asbestos Worker

11. Industry or business

FATHER
12. Name Michael E. Neary
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah C. Kane
15. Birthplace Baltimore, Md

16 (a) Informant Elenor Neary
(b) Address 1916 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 501 East 22nd St.

19 (a) (Date rec'd by registrar) (b) Huntington Ave

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946 at 7:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured neck
Pressure on Spinal Cord.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 23, 1946 9/5 M.
(b) Where did injury occur? 1916 Cecil Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall down stairs

23. Signature Benedict Skiterelic M.D.
Medical Examiner.
Date signed 3-25-46

correct age is especially important. Physicians: please write the

G37884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1172

Registered No. G37884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton
(c) Hospital or institution: St. Agnes Hospital Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles Ave. N. Englewide
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Mr. C. Raymond Anderson -

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-2194

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of ~~husband~~ or wife Evelyn Boyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1899

8. AGE: Years	Months	Days	If less than one day
46	5	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Stationery Engineer

11. Industry or business Aberdeen Proving Grounds

FATHER
12. Name Charles R. Anderson
13. Birthplace Md.

MOTHER
14. Maiden Name Cora R. Smith
15. Birthplace Md.

16 (a) Informant Mrs. Evelyn B. Anderson
(b) Address Charles Ave - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) [illegible] Huntington Williams M.D. Registrar
(Date rec'd by Local Reg.)

FEB 27 1946

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1946 at 4:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1946, to 2-25 1946, and that I last saw h/~~im~~ alive on 2/25 1946.

Immediate cause of death	Duration
Hepatic Cardiac - Respiratory failure	
Renal Failure	
Due to Paralytic Ileus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/20/46

Major findings of operation: Hepatic necrosis, peritonitis, Pancreatitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. DeElvet Jr

Address St Agnes Hosp Date signed 2/28/46

G37885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37885 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rhone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1946

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Teddy Rhone
13. Birthplace Germany

MOTHER
14. Maiden Name Alice Evans
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director

19 (a) FEB 27 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1946 10:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946 to Jan 26 1946 and that I last saw her alive on Jan 26 1946

Immediate cause of death	Duration
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Vosburgh M. D.
Address Johns Hopkins Hospital Date signed 1-30-46

VS 150

G37886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED: Parents.
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 E. York St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL KOSTIN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married, widowed, or divorced~~ Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25th 1946.

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Aurel J Kostin
13. Birthplace

MOTHER
14. Maiden Name Anna Glick
15. Birthplace Russia

16 (a) Informant Hospital Record
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan 26th '46 (month) (day) (year)
(c) Cemetery or crematory Maryland Gen Hosp.
Location

18 (a) Funeral director
(b) Address

19 FEB 27 1946 [illegible] Huntington Millington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 1946, at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1946 to 1-26 1946, and that I last saw her alive on Jan 26 1946

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: 1-26-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C D Haun M.D. M. D.
Address Maryland Gen Hosp. Date signed 1-27-46

G37887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G37887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 EUTAW PLACE
(c) Hospital or institution: ELM HURST NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. MULBERRY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM RICHARDSON EDWARDS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 14 1867

8. AGE: Years	Months	Days	If less than one day
78	6	12	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation INTERNAL REVENUE
11. Industry or business

FATHER
12. Name MORTIMER EDWARDS
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden Name SARAH ANN EDWARDS
15. Birthplace VIRGINIA

16 (a) Informant BERNICE E. SPRING
(b) Address ADAMS TOWN MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/46 (month) (day) (year)
(c) Cemetery or crematory UNION Cemetery
Location LOVETTS VILLE VA

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Maryland

19 (a) [illegible] (Local registrar) (b) Huntington Williams, M.D.

FEB 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 – 1946 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to Feb 26 1946, and that I last saw him alive on Feb 25 1946.

Immediate cause of death: Generalized Caranomatosis — Duration

Due to

Due to

Other Conditions: Myocarditis Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis L. Jacobs M. D.
Address 1700 Eutaw Pl. Date signed

Feb. 26-46

G37888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37888 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 N. Glover Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 N. Glover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM GRAY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida Bertha Gray
6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1884

8. AGE: Years	Months	Days	If less than one day
62	0	17	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Attendant
11. Industry or business: Baltimore City

FATHER
12. Name: Samuel Gray
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary Ellen Doyle
15. Birthplace: Ireland

16 (a) Informant: Mrs. Ida B. Gray
(b) Address: 727 S. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 FEB 27 1946 (Date rec'd by Local Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to Feb 24 1946 and that I last saw him alive on Feb 24 1946

Immediate cause of death: Coronary occlusion — Myocardial degeneration — Duration: 1 day / one year

Due to: Arterio-Sclerosis — Duration: Some years

Due to: — Duration:

Other Conditions: Chronic Bronchitis — Duration: Several years

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury: —

23. Signature: A. F. Rees M. D.
Address: 24 S. Broadway Date signed: Feb. 26/46

VS 150

G37889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G37889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Mc Henry st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Schmidt

3 (b) If veteran, name war WWI

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna Schmidt

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) June 31-1897

8. AGE: Years 48 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name August Schmidt

13. Birthplace Germany

MOTHER 14. Maiden Name Gertrude Adams WATSON

15. Birthplace Germany

16 (a) Informant J. Frank Schmidt

(b) Address 3009 Euclid Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore Md

18 (a) Funeral director F. B. Wagner & Son

(b) Address 300 Eutaw Place

19 (a) Filed (b) Registrar Huntington Williams M.D.

FEB 27 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25-1946 at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2/25/46 at P.M.

(b) Where did injury occur? 2008 Mc Henry st.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Gas turned on in room by unknown

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed 2-25-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G37890 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda E Gladding

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband/wife Charles Gladding
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar. 29 1888

8. AGE: Years	Months	Days	If less than one day
57	10	27	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John D Abel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie E. Windfelder
15. Birthplace Baltimore

16 (a) Informant Charles Gladding
(b) Address 1913 W Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frederick A Dole
(b) Address 1260 W Lanvale

19 (a) Huntington Williams M.D. Registrar
(Signature of registrar)

FEB 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946, at 2 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1946, to 2-26 1946 and that I last saw her alive on 2-24 1946

Immediate cause of death Cerebral Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.

Address St Josephs Hosp Date signed 2-26-46

G37891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G37891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 62 S. Carrollton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 62 S. Carrollton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Elizabeth B. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1883

8. AGE: Years	Months	Days	If less than one day
62	2	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Retired

FATHER
12. Name Clarence Phillips
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary unknown
15. Birthplace Baltimore

16 (a) Informant Mrs Mary A. Ruppel
(b) Address 62 S. Carrollton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1700 N Lombard St

19 (a) Date received by registrar FEB 27 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1946, to Feb 23 1946, and that I last saw him alive on Feb 23 1946.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular Disease	?
Due to	
Due to	
Other Conditions Arthritis Deformans	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carel Kosting M.D.
Address 1216 N. Lombard St Date signed 2/26/46 M. D.

G37892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G37892 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4037 Boarman Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4037 Boarman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Louise Gerkin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1888

8. AGE: Years	Months	Days	If less than one day
58		23	hr. min.

9. Birthplace Moundsville, W. Va.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name George V. Gocke
13. Birthplace Howesville, W. Va.

MOTHER
14. Maiden Name Lucy Mattingly
15. Birthplace Howesville, W. Va.

16 (a) Informant Geo. Ed. Gerkin
(b) Address 4037 Boarman Ave.

17 (a) Burial (b) Date thereof March 1-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Arment
(b) Address 3911 Liberty Hghts Ave.
(c) Registrar's signature Huntington Williams M.D.

FEB 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946, at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1946, to Feb 26 1946 and that I last saw h alive on 19

Immediate cause of death Coronary occlusion — Duration 5 days
Due to Arteriosclerosis — 7
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Diebold M. D.
Address 2220 Harrison Blvd Date signed Feb. 26/46.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G37893 BALTIMORE CITY HEALTH DEPARTMENT G37893
CERTIFICATE OF DEATH 45C Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Eddenhall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lennie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29 1894

8. AGE: Years 51 52 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Johnson.
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Margaret Bowley
15. Birthplace Cambridge, Md.

16 (a) Informant Virginia Evans.
(b) Address 1106 Eddenhall St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 1 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore

18 (a) Funeral director Walter B Spriggs
(b) Address 139 W Hamburg St.

Date rec'd FEB 27 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of the Uterus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed Feb. 25 1946

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37894 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 East 41st Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 East 41st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA P. METZLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widow

6 (b) Name of husband ~~or wife~~ Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1877

8. AGE: Years 68 | Months 6 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Metzell
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret Kurtz
15. Birthplace Balto., Md.

16 (a) Informant Margaret Mowing
(b) Address 808 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)

(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director John J. McGann
(b) Address 3600 E. Baltimore St.

FEB 27 1946 (Date rec'd by registrar) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25/46 19..., at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Varicose Ulcers

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 2/26/46

VS 151

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 172

G37895 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~ (b) County Denmark
(c) City or town Copenhagen (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Stenegade (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No) If yes, name country Denmark

3 (a) FULL NAME (Paul Johannes Olfert Lorentzen) Paul Johannes Lorentzen
3 (b) If veteran, name war ~
3 (c) Social Security Account No. ~

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: MRS. E. LARSEN (Not Available)
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 31, 1918

8. AGE: Years 27 | Months 6 | Days 24 25 | If less than one day ____ hr. ____ min.

9. Birthplace Copenhagen, DENMARK (Town, county, and state)
10. Usual Occupation A-B Seaman
11. Industry or business East Asiatic S.S. Company

FATHER
12. Name Not Available
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant HINKINS S. S. Agency
(b) Address 1616 Munsey Bldg.-City

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto., Md.

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. WOODEN SUC.) 1416 N. HOWARD AVENUE
(b) Address
FEB 27 1946
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946, at 2:40 AM P

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intracranial hemorrhage.
Due to
Other Conditions Fractured left leg.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/1
(a) Date of injury February 25, 1946
(b) Where did injury occur? Pier 6 Locust Point
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fall from ship

23. Signature Benedict Sbitarelli M.D. Medical Examiner.
Date signed 2-26-46.

VS 151

Please write the information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37896 X G37856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 54.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sparrows Pt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 E. 34th.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hughes Ross

3 (b) If veteran, name war No
3 (c) Social Security Account No. 213-07-1064

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Lula Grace
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 4/9/1887
8. AGE: Years 58 Months 10 Days 17 If less than one day hr. min.
9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Bet. Steel Co.

FATHER
12. Name Charles Ross
13. Birthplace Balto
MOTHER
14. Maiden Name Catharine Baker
15. Birthplace

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-46 (month) (day) (year)
(c) Cemetery or crematory Lorelmont
Location Baltimore

18 (a) Funeral director Shuford Funeral Co.
(b) Address 108 W. Mt. Royal Ave.

19 (a) FEB 27 1946 (b) Registrar
(Date received) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26-1946 at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1946, to 2-24 1946 and that I last saw h[illegible] alive on 2-21-1946.

Immediate cause of death Coronary Thrombosis — Duration 5d.
Due to Coronary Sclerosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home Date signed 2-26-46

X

G37897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1942

G37897 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd.
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo. 7 da
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo. - 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State R. I. (b) County —
(c) City or town Riverside (If outside city or town limits, write RURAL and give town)
(d) Street No. —
(e) Citizen of foreign country? — 10 — (If rural give location) (Yes or No)
If yes, name country —

3 (a) FULL NAME Sister M. Imelda Scallin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1872

8. AGE: Years 73 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Pawtucket Rhode Island (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Henry Scallin
13. Birthplace Pawtucket R.I.

MOTHER
14. Maiden Name Sarah Goodwin
15. Birthplace Pawtucket, R. I.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-46 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location Manville - R. I.

18 (a) Funeral director Sullivan Mortuary
(b) Address 108 W. Monument Ave.

19 2 27 1946 (b) Registrar
(Date rec'd by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1946, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1946, to Feb 27 1946, and that I last saw her alive on Feb 27 1946.

	Duration
Immediate cause of death: Myocardial Infarcte	8 days.
Due to:	
Due to:	
Other Conditions: Pre-senile psychosis (alzheimers disease) (Include pregnancy within 3 months of death)	6 yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Magee M. D.
Address 33 Hawthorne St. Date signed

X

G37898
CWK-98502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G37898 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 20-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 S. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Neuman (Newman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Neuman Newman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31-1926

8. AGE: Years	Months	Days	If less than one day
20	10	25 24	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore B. Laisure
13. Birthplace D. C.

MOTHER
14. Maiden Name Mary Valentine
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

19 (a) FEB 27 1946 (Date received by registrar) Herrington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1946, at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1946 to Feb. 24 1946, and that I last saw her alive on Feb. 24 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 2/25/46

VS 150

G37899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V54a

G37899 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-29

8. AGE: Years 16 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Parker
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Frazier
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Cumberland Md.

18 (a) Funeral director Louis Stein Jr.
(b) Address Cumberland Md.

19 (a) (Date received by registrar) FEB 27 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1946 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1946 to Feb 27 1946 and that I last saw h[illegible] alive on Feb 27 19 46.

Immediate cause of death Brain tumor — Edema & III Ventricle

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/23/46

Major findings of operation: Brain Tumor — III Ventricle

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth W. Saunders M.D.
Address Ruth Williams Apt Balto. Md. Date signed 2/27

G37900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. G37900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen Cassard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Col. H. D. Cassard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1893

8. AGE: Years 52 | Months 8 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Wade H. D. Warfield
13. Birthplace Md

MOTHER
14. Maiden Name Blanche Wetherhead
15. Birthplace W. Va.

16 (a) Informant Col. H. D. Cassard
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-46 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cem.
Location Howard Co., Md.

18 (a) Funeral director C. Harry Deer
(b) Address Sykesville, Md.

(Date received by local registrar) FEB 28 1946 (Signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946, 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946, to 2-26 1946, and that I last saw her alive on 2-26 1946

Immediate cause of death: Lysol poisoning
Cardiac arrest
Anuria - uremia - coma - collapse — Duration 48 hrs
Due to Acute tubular necrosis of kidneys
Due to Lysol poisoning, acute — 48 hrs
Multiple fractures, intracranial injury
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy Lysol poisoning. Acute nephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Suicide
(b) Date of occurrence 2-24-46 at 8 AM
(c) Where did injury occur? Sykesville (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Ingestion of Lysol

23. Signature John Z. Bowers
Address 20 E. Preston St. Date signed 2-27-1946

Howard J. Moseley, M. D.

G37901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G37901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1344 N. Stricker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Bary marsh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Carrie Marsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1875

8. AGE: Years 70 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Marsh
13. Birthplace N.C.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Carrie Marsh
(b) Address 1344 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location md

18 (a) Funeral director George D. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) Date received (year) Huntington Williams M.D. Registrar

FEB 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25- 1946 at 9 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9- 1945 to 2-25- 1946
and that I last saw h alive on 2-25- 1946

Immediate cause of death Chronic Valvular Heart Disease — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George C. Page M.D.
Address 1567 Mosher St. (17) Date signed 2-27-46

X

G37902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1117a

Registered No. G37902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1448 N. Mount Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN O. GILMER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) DEC. 5 1901

8. AGE: Years	Months	Days	If less than one day
44	2	22	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Rev. S. G. Gilmer
13. Birthplace N.C.

MOTHER
14. Maiden Name Lula Brown
15. Birthplace N.C.

16 (a) Informant Allie Parham
(b) Address 1939 Prestman St.

17 (a) Burial-Removal (b) Date thereof Feb. 28, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location GREENSBORO, NORTH CAROLINA

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 Penna. Ave. Balto. I.

19 (a) (Date received by registrar) (b) Registrar

FEB 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27- 1946, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946, to 2-27 1946, and that I last saw him alive on 2-27 1946.

Immediate cause of death	Duration
Carcinoma	
Fracture - + perforated	
Osculan colitis	
Due to General Peritonitis	
Due to Ruptured peptic ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-24-46
Major findings of operation: Suspected peptic ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Shuford M.D.
Address Mercy Hosp Date signed 2-27-46

Huntington Williams, M.D.

G37903

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1013

Registered No. G37903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Patterson Park Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA STRAUSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Louis Strauss
13. Birthplace Austria

MOTHER
14. Maiden Name Ella -
15. Birthplace Md

16 (a) Informant Mrs. Anna Kleinschmidt
(b) Address 1201 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-46 (month) (day) (year)
(c) Cemetery or crematory West Blvd
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Balto. St

19 (a) (Date received by registrar) Huntington Williams, Mgr

FEB 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1946, at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1946, to 2-27 1946, and that I last saw her alive on 2-27 1946.

Immediate cause of death: Pulmonary embolism
Thrombosis femoral veins
Due to Regional ileitis
malnutrition & cachexia
Due to

Duration
minutes
?
- 3 days

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnall Katz M. D.
Address Sinai Hosp Date signed 2-27-46

Balt X

G37904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G37904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 250 N. Schroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 250 N. Schroeder St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Walker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/16/46

8. AGE: Years — Months — Days — If less than one day 4 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business —

FATHER
12. Name Egbert Williams
13. Birthplace Unknown

MOTHER
14. Maiden Name Gertrude Walker
15. Birthplace Chollyhoke, Va.

16 (a) Informant Gertrude Walker
(b) Address 250 N. Schroeder St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins University Medical School FEB 27 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

FEB 28 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

3324

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946, at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3:50 A.M. 2/16 1946 to 3:30 P.M. 2/16 1946, and that I last saw h.e.r. alive on 6 A.M. 2/16 1946.

Immediate cause of death	Duration
Parmaturity - 30 wks	
Due to Causes unknown	
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Huntington Hospital, signed

637905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

637905 Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Dry Calvert
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 East 32nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Hoshall
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 12, 1922
8. AGE: Years 23 Months 4 Days 15 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Clarence Hoshall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ida Pacey
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Irma Harvey (Sister)
(b) Address 417 E. 32nd St. City #18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2/1946 (month) (day) (year)
(c) Cemetery or crematory Greenwood
Location Chincoteague Va.

18 (a) Funeral director Harry N Armacost
(b) Address 4204 Ridgewood Ave Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

VS FEB 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1946 to Feb 27 1946, and that I last saw her alive on Feb 27 1946.

	Duration
Immediate cause of death Uremia	5 days
Due to Chronic glomerulonephritis	
Due to Hypertensive cardiovascular	disease
Other Conditions Rheumatic heart disease	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature A. Erskine Hamill M.D.
Address Union Memorial Date signed 2/27/46 M. D.

X SPROUL

G37906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G37906

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E. Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1953 Walnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP CASHMYER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Bessie Cashmyer
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Nov 1 - 1884
8. AGE: Years 61 | Months 3 | Days 25 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Bowling Alleys

FATHER
12. Name Wm H Cashmyer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rosie Weisman
15. Birthplace Baltimore

16 (a) Informant Mrs Bessie Cashmyer
(b) Address 1953 Walnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March - 1946 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Lemmert Funeral Home
(b) Address 2008 Eutaw St

19 (a) (Date signed) FEB 28 1946 (b) Huntington Williams, M.D. (Physician)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946 at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1946 to 2-26 1946 and that I last saw h. living alive on 2-25 1946

Immediate cause of death	Duration
Carcinoma of Bladder with metastases	2 yrs +
Due to Pulmonary Edema due to Hypertensive Failure	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-1-46
Major findings of operation: Carcinoma trigone Bladder
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Gordon M.D.
Address Sinai Hospital Date signed 2/26/46

G37907 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G37907 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 E. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married.

6 (b) Name of husband or wife Mammie (Worsham)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 - 1884

8. AGE: Years	Months	Days	If less than one day
62	-	4	hr. min.

9. Birthplace Chatham Va.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Waketela.

FATHER
12. Name Robert Moore
13. Birthplace Va.

MOTHER
14. Maiden Name Sally Hancock
15. Birthplace Va.

16 (a) Informant Mrs Mammie Moore
(b) Address 3618 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 1 / 46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John J Connelly
(b) Address 418 Eastern Ave. Essex 21

19 (a) (b)
(Signature of Registrar)

FEB 28 1946
VS 1M
Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 11 1945 to Feb 26 1946, and that I last saw him alive on Feb 26 1946

Immediate cause of death Coronary Occlusion — Duration 7M. 24 H

Due to Ch Myocarditis — Duration Jan 45

Due to Arteriosclerosis — Duration 1942

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Rogers M. D.
Address 801 H Kenilworth Date signed 2/27/46

X

G37908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G37908 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3727 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Medinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Anna Rice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8-1898

8. AGE: Years 47 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Unemployed

FATHER
12. Name Harry H. Medinger
13. Birthplace Balto.

MOTHER
14. Maiden Name Julia C. Z
15. Birthplace Balto.

16 (a) Informant Florence Medinger
(b) Address 3724 E. Lombard St.

17 (a) Burial (b) Date thereof Feb. 28. 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North + Myrtle Ave.

18 (a) Funeral director John S. Connelly
(b) Address 418 Eastern Ave. Balto

19 (a) (Date received by registrar) FEB 28 1946 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1946, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. L. Turbowitz M.D.
Medical Examiner.
Date signed 2-26-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G37909

CERTIFICATE OF DEATH 33a

Reg. Dist. No. .....

G37909

1. PLACE OF DEATH:

County .....

City or town Balto. City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 515 S. Washington St.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County .....

City or town Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 S. Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME John T. Shannon

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife Minnie Shannon nee Brightwell 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 21 1881

8. AGE: Years	Months	Days	If less than one day
64	5	-	..... hrs. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual occupation Lumber, Inspector,

11. Industry or business Hugh F. Parker

FATHER 12. Name Augustus Shannon

13. Birthplace Balto.

MOTHER 14. Maiden name Mary Ann Cravens

15. Birthplace Balto.

16. Informant Mrs. Cath. Ahrns

Address 425 Maryland Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-46 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave. Rd.

18. Funeral director John G. Connelly

Address 2nd & Washington Court. Wd. St. Williamsport

19. FEB 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 — 1946, at 5-16 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1946, to Feb 21 1946 and that I last saw h... alive on Feb 21 1946

Immediate cause of death	DURATION
Influenzal Pneumonia	1 wk
Pulmonary Edema	1 day
Due to Hypostatic Lungs	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Geo. D. Lefevre M. D., or other

Address 42 E. Preston Apt 4 Date signed 2-25-46

G37910 G37910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 534 S. Caea St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 S. Caea St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Gink

3 (b) If veteran, name war ~
3 (c) Social Security Account No. ~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower

6 (b) Name of husband or wife late Edna
6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) March 19th 1888

8. AGE: Years	Months	Days	If less than one day
57	11	8	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Michael Gink
13. Birthplace Lithuania

MOTHER
14. Maiden Name Ankenpox
15. Birthplace Lithuania

16 (a) Informant Dr Joseph M Gink
(b) Address 534 S. Caea St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 900-03 Hollins St

19 (a) (Date received by Registrar) (b) Registrar

FEB 4 1946 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 27th 1946, at 8:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1946, to 2/27 1946 and that I last saw him alive on 2/27 1946

Immediate cause of death Cerebral Hemorrhage — Duration 1 da
Due to Hypertensive Cardio-Vascular Renal Disease — Duration yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph M Gink M.D.
Address 534 S. Caea St Date signed 2/27/46

X

G37911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G37911 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Dankmeyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/1882

8. AGE: Years: 64 | Months: 0 | Days: 24 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Time Keeper

11. Industry or business Bethlehem - Fairfield

FATHER
12. Name Wm. Dankmeyer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Anna M. Hinkler
15. Birthplace Balto., Md.

16 (a) Informant Mr. Clarence Dankmeyer
(b) Address 2831 Guilford Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 28 1946 (Date received by Registrar) (b) Huntington Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1946, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1946, to 2/26 1946, and that I last saw him alive on 2/26 1946.

	Duration
Immediate cause of death: Cirrhosis of Liver	
Due to: Chronic alcoholism	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Bobby L. James M. D.
Address Franklin Square Hosp. Date signed 2/26/46.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G37912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G37912 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 Old York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Old York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert R Compton

3 (b) If veteran, name war W | 3 (c) Social Security Account No. 2[illegible]8A

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Susan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1872

8. AGE: Years 73 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)

10. Usual Occupation Shoe Worker

11. Industry or business Shoe Mfg

FATHER 12. Name William Compton
13. Birthplace Md

MOTHER 14. Maiden Name Louise Hosan
15. Birthplace Md

16 (a) Informant Rose Lemmy
(b) Address 3705 Old York Rd

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 3/1/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wilson Service
(b) Address 1210 Park Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 28 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1944, to 2-26 1946, and that I last saw h[illegible] alive on 2-26 1946.

Immediate cause of death Bronchopneumonia
with Pulmonary edema

Due to

Due to

Other Conditions Arterio-sclerosis
Myocarditis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

Duration
2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Hooper M.D.
Address 3534 Ellerslie Date signed 28 Feb

X

G37913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H Registered No. G37913

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Garrett Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Livingston Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-3735

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1898

8. AGE: Years 48 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Electrician

11. Industry or business: Morris-Ward Electric Co.

FATHER
12. Name: John Smith
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Margaret (Unknown)
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Anna M. Bitzel
(b) Address: 405 Ilchester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (Date received by Registrar) FEB 28 1946 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946 at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 26, 1946
(b) Where did injury occur? 2617 Garrett Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Asphyxiation by illuminating gas

23. Signature Benedict Stabile M.D.
Date signed 2-27-46 Medical Examiner.

VS 151

G37914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Register No. G37914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 W. Conway St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 W. Conway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Rice

3 (b) If veteran, name war: World War # 1

3 (c) Social Security Account No. 220-09-2146

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1/(18)87

8. AGE: Years	Months	Days	If less than one day
(50) 58	4	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Wm. F. Rice
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Annie Gross
15. Birthplace Md

16 (a) Informant Sarah Rice (Wife)
(b) Address 628 W. Conway St.

17 (a) Burial (b) Date thereof 2/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore, National
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (b)
(Signature of Registrar)

FEB 28 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/46 19..., at 8:40 M

21. I certify that death occurred on the date above stated: that I attended deceased from Dec 3 1945 to Feb 24 1946, and that I last saw h[illegible] alive on Feb 24 1946.

Immediate cause of death Coronary Thrombosis — Duration 3 mos.

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Shepperd M. D.
Address 1631 W. Franklin St Date signed 2/28/46

EP 150

Washington Willesden, Md

X

G37915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G37915 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynard & Rutland
(c) Hospital or institution: West Balto Gen Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 CALVERTON HIGHTS AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Valentine Degen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MARY M. DEGEN
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) JUNE 30 1887

8. AGE: Years 58 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation PAPER HANGER.

11. Industry or business —

FATHER 12. Name GEORGE DEGEN
13. Birthplace BALTO. MD.

MOTHER 14. Maiden Name MARY SULTAIR
15. Birthplace BALTO MD

16 (a) Informant MARY. M DEGEN
(b) Address 2432 CALVERTON HIGHTS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-2-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Mrs Theo A. G. Rohde
(b) Address 2325 Edmondson Ave

19 (a) FEB 28 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 February 1946 at 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Feb 1946 to 27 Feb 1946 and that I last saw h/m alive on 27 Feb 1946

Immediate cause of death: Circulatory Failure — Duration

Due to Aortic Stenosis — Mitral Insufficiency

Due to Rheumatic C.V. Dis.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leslie A. Hall Jr M. D.
Address West Balto Gen Hosp Date signed 2/27/46

Huntington Hill Registrar

VS 150

G37916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G37916 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Arthur

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6212 Tramore Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wayne Meisner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 9 1943

8. AGE: Years	Months	Days	If less than one day
2	5	20	— hr. — min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm. E. Meisner
13. Birthplace Penn

MOTHER
14. Maiden Name Mary Elizabeth Bauer
15. Birthplace Md.

16 (a) Informant Mrs. Wm. E. Meisner
(b) Address 6212 Tramore Rd. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1 1946 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace, Md

18 (a) Funeral director P. Madigan Mitchell
(b) Address Havre de Grace, Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2nd and 3rd degree burns involving 60% of body surface

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 26, 1946 at 2:30 P.M.
(b) Where did injury occur? 6212 Tramore Rd
(c) Did injury occur at home, on farm, industrial place, in public place? No While at work? No
(d) Means of injury Clothes caught fire from open fire

23. Signature Benedict Shtarkis M.D. Medical Examiner.
Date signed 2-28-46

G37917 Woodland + Allamon

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G37917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Penna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clemmie Stephens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1900

8. AGE: Years 45 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Huntsville, Ala (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Ala

MOTHER
14. Maiden Name Maria Stephens
15. Birthplace Ala

16 (a) Informant Blanch Tilden
(b) Address Aberdeen Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2-1946 (month) (day) (year)
(c) Cemetery or crematory Huntsville Ala
Location Ala

18 (a) Funeral director Henry Fanning Sons
(b) Address Aberdeen Md

19 (a) Date received by Registrar FEB 28 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946 at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1945 to 2-26 1946 and that I last saw h.. alive on 2-24 1946

Immediate cause of death Acute Pulmonary Congestion, | Duration
Due to Congestive Heart failure
Aortic Regurgitation
Due to Cardiac Dilatation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Woodland M. D.
Address 8-6 Aberdeen Md Date signed 2-28-46

G37918

BALTIMORE CITY HEALTH DEPARTMENT

TN. 99275

CERTIFICATE OF DEATH 107

Registered No. G37918

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elaine Joyce Henson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24h 1945

8. AGE: Years	Months	Days	If less than one day
	10	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Raymond Henson
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorothy Henderson
15. Birthplace N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 3/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph G. Lockard
(b) 1304 N. Central Ave

19 (a) FEB 28 1946 (b) Huntington Hill Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26th 1946 19 , at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14th 19 46 to Feb. 26 19 4 , and that I last saw her alive on Feb. 26 19 46

Immediate cause of death Feb. 26th 1946
Pneumonia
Duration 7 hrs.

Due to Pneumonia organism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard C. Jones M. D.
Address Balto. City Hosp. Date signed 2-27

X

G37919 | BALTIMORE CITY HEALTH DEPARTMENT | G37919

CERTIFICATE OF DEATH 1937

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dist.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E. Ware St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Montford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Gloucester, Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name unknown
	13. Birthplace
MOTHER	14. Maiden Name
	15. Birthplace

16 (a) Informant Louise Scott
(b) Address 11 E. Ware St

17 (a) Burial (b) Date thereof 3-1-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Date rec'd by Registrar FEB 28 1948 (b) Filed by Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1946, at 3:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Sullivan M.D.
Medical Examiner.
Date signed 2/24/46

G37920 Ward 7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 157 E G37920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 Enon St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Lee.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-46

8. AGE: Years | Months | Days: 6 | If less than one day: 17 hr. 30 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Robert Lee
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Lee
15. Birthplace Va.

16 (a) Informant Annie Lee
(b) Address 155 Enon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Adolphus Halstead

18 (a) Funeral director 918 Druid Hill Ave
(b) Address

FEB 28 1946
Registered by Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1946, to 2-26 1946, and that I last saw her alive on 2-26 1946

	Duration
Immediate cause of death Bronchopneumonia	two days
Due to Complications	6 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Lorenz Jones M. D.
Address 1100 Druid Hill Ave Date signed 2-27-46

VS 150

X

G37921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G37921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1044 N. Eden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry McNutt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Lillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29 1893

8. AGE: Years	Months	Days	If less than one day
52	6	26	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Operator in Laundry

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Alice Brown
15. Birthplace Va.

16 (a) Informant Marabe Adams
(b) Address 813 Somerset St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County

18 (a) Funeral director Mrs. Peter A. Elliott
(b) Address 1129 N. Carlton St

19 (a) Huntington Williams, M.D. Registrar

FEB 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1946 to 2/25 1946 and that I last saw him alive on 1/25 1946.

Immediate cause of death Pulmonary Hemorrhage — Duration 9

Due to Bilateral Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Julian M. D.
Address 4346 23d St Date signed 2/27/46

G37922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164D

Registered No. G37922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 Elm Tree St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town, write RURAL and give town)
(d) Street No. 1520 Elm tree St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Balbina Stec

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Stec

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) – – 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER
12. Name Thomas Lucezuk
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Andrew Stec
(b) Address 1520 Elmtree St

17 (a) Burial (b) Date thereof March 2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross A.A.Co
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave

19 FEB 28 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 26 1946, at 1:25 M

21. I certify that I took charge of the remains described above, held an Inspectum thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot Stab Wound of Neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 26 1946 M.
(b) Where did injury occur? 1520 Elm Tree St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbing & Shooting

23. Signature Albert A. Krauter M.D.
Medical Examiner.
Date signed 2-26-46

VS 151

G37923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G37923 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure to give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Finksburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt #1 (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ NO (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Lambert
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~or wife~~ Roger Lambert
6 (c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) April 9 - 1911
8. AGE: Years 34 | Months 10 | Days 17 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business
FATHER 12. Name Hugh Helbridle
13. Birthplace Maryland
MOTHER 14. Maiden Name Georgie Shoemaker
15. Birthplace Maryland
16 (a) Informant Roger Lambert
(b) Address Finksburg Rt #1
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MARCH 3 1946 (month) (day) (year)
(c) Cemetery or crematory Ch of God Cem.
Location UNIONTOWN, MD.
18 (a) Funeral director H.B. Bankard & Son
(b) Address Westminster, Md.
(c) Signature of Registrar Wellington Williams M.D.
FEB 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1946 at 8:25 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1946, to 2/28 1946, and that I last saw h~~er~~ alive on 2/28 1946
Immediate cause of death Respiratory Failure - | Duration
Due to Metastatic Cat
Due to Pneumococcal Sep.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 2-14-46
Major findings of operation: Cancer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C.W. Baggett M.D.
Address Finksburg Date signed 2/28/46

VS 150

over

G37924

G37924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 E 32nd St
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E 32nd St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Harry Gough McComas

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-6076

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Emily C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1875

8. AGE: Years	Months	Days	If less than one day
70	5	20	hr. min.

9. Birthplace Joppa Harford Md
(Town, county, and state)

10. Usual Occupation Engineer B & RR

11. Industry or business Railroad

FATHER
12. Name Geo. W. McComas
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Norris
15. Birthplace Maryland

16 (a) Informant Harry G McComas Jr
(b) Address 822 Gallatins St Wash DC

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar 1 1946 (month) (day) (year)
(c) Cemetery or crematory Union Chapel
Location Wilson Md

18 (a) Funeral director Everard K. McCormas Sons
(b) Address Aberdeen Md

19 (a) (Date rec'd by registrar) (Huntington Williamsport, Md.) Registrar

FEB 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946; at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1946, to Feb. 26 1946, and that I last saw h~~im~~ alive on Feb. 26 1946.

Immediate cause of death	Duration
Chronic Nephritis	3 yrs.
Due to	
Due to	
Other Conditions Cystoris - tuberosis & Chronic Myocarditis. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry A Storey M. D.
Address 2304 N Paca St Date signed 3/2/46

CWK-[illegible] G37925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G37925 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas J. Anderson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
92 ?			hr. min.

9. Birthplace Not known (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/28/46 (month) (day) (year)
(c) Cemetery ~~crematory~~ Hollywood
Location Richmond, Va.

18 (a) Funeral director Wm. J. Fisher & Sons
(b) Address M. & Pa. Ave. Balto. 17, Md.

19 (a) (Local registrar) (b) Huntington Williams, Registrar

FEB 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1946 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1946 to Feb. 28 1946 and that I last saw h[illegible] alive on Feb. 28 1946

Immediate cause of death
Cellulitis, Left Foot
GANGRENE, arteriosclerotic
Due to Left Foot

Due to Arteriosclerotic Heart Disease

Other Conditions Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy None

Duration
Unknown
Unknown
Unknown
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
15. Signature Fred E. Nutterville M. D.
Address Baltimore City Hosp. Date signed 2-28-46

D G37926 Davis

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

G37926 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1895

8. AGE: Years 51 | Months - | Days 11 | If less than one day hr. min.

9. Birthplace Mecklenburg Co Va
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Jasper
13. Birthplace Va

MOTHER
14. Maiden Name Jennie Burrough
15. Birthplace Va

16 (a) Informant Samuel Walker
(b) Address 1615 Millman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Broadway ave

19 (Date rec'd by registrar) FEB 28 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27-46 19 , at 5:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22-46 19 to 2-27-46 19 and that I last saw h[illegible] alive on 2-27-46 19

Immediate cause of death	Duration
Hypertensive Cardio-Renal Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Williams M. D.
Address 312 E 23rd St Date signed 2-28-46

VS 150

G37927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G37927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Broadmoor Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA KREBS SHOEMAKER

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Female	White	Widow

6 (b) Name of husband or wife: Charles E. Shoemaker
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1864

8. AGE: Years	Months	Days	If less than one day
81	2	7	hr. min.

9. Birthplace: Lock Haven Pa. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Richard Krebs
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Sarah Garskaddon
15. Birthplace: Pa.

16 (a) Informant: Mrs. George R. Haworth
(b) Address: 300 Broadmoor Rd.

17 (a) transit Permit (Burial, cremation, or removal) (b) Date thereof 3/1/46 (month) (day) (year)
(c) Cemetery or crematory: Lock Haven Pa.
Location:

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) (b)

FEB 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27, 1946 at 8P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13/44 to 2/27/1946 and that I last saw h[illegible] alive on 2/27/1946

Immediate cause of death: Cerebral hemorrhage (left) — Duration: 36 hrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H. W. Harper
Address: 5701 Evergreen Oakleigh Signed 2/28/46

Huntington Williamsport Md.

X

G37928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G37928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. - 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Lindsay Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1903

8. AGE: Years 42 (32) | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Cenna (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Anthony Iuciasano
13. Birthplace Italy

MOTHER
14. Maiden Name Agnes V. Ardal
15. Birthplace Italy

16 (a) Informant Henry S. Fisher
(b) Address Harrisburg

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3 4 46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harrisburg Pa.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

FEB 28 1946
VS 151

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 24 1946, at 3:35 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Deep laceration of throat involving large vessels and trachea.
Stab wounds of chest and abdomen.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 24, 1946
(b) Where did injury occur? 1430 Lindsay Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Throat slashed by razor

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 2-24-46

X

HEALTH DEPARTMENT—CITY OF BALTIMORE

G37929

CERTIFICATE OF DEATH

16

G37929

1. PLACE OF DEATH

Registered No.....

CITY OF BALTIMORE: (No. James Lawrence Kernan St. Ward) Crippled Children Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ....yrs....mos....ds. How long in U. S. If of foreign birth?....yrs....mos....ds.

2. FULL NAME Floyd Johnson 25-2 If U. S. Veteran specify WAR

(a) Residence: No. 410 Seagull Ave St. Cherry Hill Ward. Baltimore, Maryland

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	Negro	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) March 1, 1944

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Melvin Tilley

14. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

MOTHER

15. MAIDEN NAME Mildred Johnson

16. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

17. INFORMANT Mildred Johnson

(Address) 410 Seagull Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Just Cem. Date 3/6 1946

19. UNDERTAKER Chas. H. Alexander

(Address) 1200 McCulloch Street

20. FILED 3/11/46 Worthington-Williams Co.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) February 27, 1946

22. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1946 to February 27, 1946

I last saw him alive on Feb. 27, 1946 Death is said to have occurred on the date stated above, at 2 20 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Meningitis, tuberculous	2-21-46

Other contributory causes of importance:

Miliary Tuberculosis, lumbar vertebrae

Was an operation performed? No Date of

For what disease or injury?

Name of operation —

What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Nat Date of injury ....., 19....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) Geo B Baron M. D.

(Address) Kernan Hospital

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 28 1946

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G37930 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 105 days
(e) Length of stay in Baltimore (yrs., mos., or days) 105 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Wis. (b) County
(c) City or town Eauclaire (If outside city or town limits, write RURAL and give town)
(d) Street No. 241 Lake St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Cross, Dorothy Mabel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1899

8. AGE: Years 47 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace: Shoreham, Vermont (Town, county, and state)
10. Usual Occupation: Asst. Nurse Office
11. Industry or business: US Public Health Service

FATHER
12. Name: Charles Smith
13. Birthplace: Vt.

MOTHER
14. Maiden Name: Miriah Towner
15. Birthplace: Vt.

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2-4 (month) (day) (year)
(c) Cemetery or crematory Middlebury, Vermont
Location Vermont

18 (a) Funeral director O'Day Funeral Home Inc.
(b) Address 4644 York Road

19 MAR 1 - 1946 (b) Huntington Williams, M.D. (Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1946, at 8:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1945, to Feb. 27 1946, and that I last saw h im alive on Feb. 27 1946.

Immediate cause of death: Carcinoma of ovary with generalized peritoneal metastasis — Duration: UNKNOWN
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/28/46
US Marine Hospital, Balto, Md.

G37931

CWK-35459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156a

Registered No. G37931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 7- 4- 10-3
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Maryland Penitentiary (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Matthew Narog

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7-1912

8. AGE: Years 33 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Narog
13. Birthplace Europe

MOTHER
14. Maiden Name Julia Ann Kaitiesch
15. Birthplace Europe

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St

MAR 1 - 1946 (Date rec'd by registrar) (b) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH February 26 1946, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1938, to Feb. 26 1946, and that I last saw him alive on Feb. 26 1946.

Immediate cause of death: Unknown - probably Chronic Wasting Disease

Duration:

Due to

Due to

Other Conditions Infectious Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Gangrenous ? ischiorectal abscess, history of diabetes

Date of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Hubbard

Address B C H Date signed 2/28/46 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 C

G37932

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARINE HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: ABOARD: S.S. ARIEL FOSTER, CANTON.
(a) State CALIF. (b) County
(c) City or town Belmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 895 Laurel Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. MURPHY

3 (b) If veteran, name war

3 (c) Social Security Account No. 534-16-7916

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
MALE	WHITE	Married

6 (b) Name of ~~husband or~~ wife Beatrice Murphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1900

8. AGE: Years	Months	Days	If less than one day
45	7	7	hr. min.

9. Birthplace Missouri
(Town, county, and state)

10. Usual Occupation Chief Officer

11. Industry or busin Matson Navigation Co

FATHER
12. Name (Unknown) Murphy
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informan Capt. T.D. Halliday
(b) Addres Dollarman S.S. Co.

17 (a) Cremation (b) Date thereof 3/2/46
~~(Burial, cremation, or removal)~~ (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 MAR 1 - 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25- 19 46, at 2 25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Myocardial failure

Due to Rheumatic endocarditis
Cardiac hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Sbarbaro M.D.
Medical Examiner.
Date signed 2-26-46

VS 151

G37933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

G37933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 N. Patterson Pk. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH HENRY GRULLEMEYER

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 215-09-5034

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma B. Grullemeyer (Nee Barth)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business Jos. H. Grullemeyer

FATHER
12. Name Morritz
13. Birthplace Vienna, Austria

MOTHER
14. Maiden Name Paarfus
15. Birthplace Vienna

16 (a) Informant Mrs. Emma B. Grullemeyer
(b) Address 1500 N. Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MAR 1 - 150 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Feb 27 1946 and that I last saw h alive on Feb 26 1946

Immediate cause of death: Hepatic Cirrhosis — Duration: 1 yr

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz J Krimgen M. D.
Address 2700 Harford Road Date signed Feb 28 1946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G-229934 — R G-229934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos-7days
(e) Length of stay in Baltimore (yrs., mos., or days) 12mos. 7days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: George Nichols

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2-1925

8. AGE: Years	Months	Days	If less than one day
20	2	24	hr. min.

9. Birthplace Salisbury, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Erman Nichols (D)
FATHER — 13. Birthplace Salisbury, Md.

MOTHER — 14. Maiden Name Lettie Gattis (D)
MOTHER — 15. Birthplace Salisbury, Md.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-46 (month) (day) (year)
(c) Cemetery or crematory
Location Tyaskin, Maryland

18 (a) Funeral director C. Glenn Messick
(b) Address Bivale, Maryland.

19 (a) Date received by Registrar MAR 4 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26- 1946, at 8.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19- 1945 to 2-26- 1946, and that I last saw him alive on 2-26- 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 3/4/46

G37935 ✓ G37935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 256 N. Exeter St.
(c) Hospital or institution: 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
2 City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 256 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Glorioso.

3 (b) If veteran, name war: W. War 1st.

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife: Aurora Glorioso

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16 1886

8. AGE: Years 59 | Months 4 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Cefalu Italy
(Town, county, and state)

10. Usual Occupation Fruit Merchant

11. Industry or business

FATHER
12. Name Carmelo Glorioso
13. Birthplace Italy

MOTHER
14. Maiden Name Rosolia Glorioso
15. Birthplace Italy

16 (a) Informant Aurora Glorioso (Wife)
(b) Address 1504 Hoffman St.

17 (a) Burial (b) Date thereof March 2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balt. Natio. Cematory
Location 5501 Frederick Ave Bal. Md.

18 (a) Funeral director Frank Della Rosa
(b) Address 52 N. Morley St.

19 (a) ... (b) ...
(Date received by registrar) Huntington-Williams, Md. [illegible]

VS 189

MAR 1 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1946, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Feb 28 1946, and that I last saw him alive on 1946

Immediate cause of death ARTERIOSCLEROSIS, S. HYPERTENSION — Duration 5 Yrs
Due to CORONARY THROMBOSIS. — 5 Yrs
Due to — 3 Days
Other Conditions CEREBRAL HEMORRHAGE — 1 Yr.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Carpenter MD
M.D. or Coroner
Date signed 2-28-46

G37936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G37936
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: J. Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 246 N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Catalfamo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Joseph

6 If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-2-1897

8. AGE: Years	Months	Days	If less than one day
48	3	22	3 hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Frank Avanzo
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Italy

16 (a) Informant Joseph Catalfamo
(b) Address 246 N. Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Baltimore Md

18 (a) Funeral director Grauel Bella Undertaking Co.
(b) Address 52 W. Hanley St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M. D.

1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1946 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1946 to 2-28 1946 and that I last saw h[illegible] alive on 2-28 1946.

Immediate cause of death	Duration
Respiratory Failure	
Cause	
Due to Cardiac failure	
Due to Hypertension and arteriosclerosis - heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Yeskey M. D.
Address Johns Hopkins Hosp Date signed 3-4-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN. G37937 77538

BALTIMORE CITY HEALTH DEPARTMENT ✓ G37937

CERTIFICATE OF DEATH

131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 4- 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME James Shields

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3rd. 1880

8. AGE: Years 65 | Months 11 | Days 24 | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Bernard Shields
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Cassby
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAR 1 1946 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27th 1946 19 at 4.50 P M

21. I certify that death occurred on the date above stated: that I attended deceased from Oct. 21 1942 to Feb. 27 1946 and that I last saw him alive on Feb. 27 1946

Immediate cause of death: Bronchopneumonia — Duration 10 days

Due to:

Due to:

Other Conditions: Cerebral Thrombosis, Hypertension — Duration 3 years
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Consent

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Lund M. D.
Address Baltimore City Hospitals Date signed 2-28-46

Huntington Williams M.D.

107

G37938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

G37938 Registered No.

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2056 E. Hoffman Street
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2056 E. Hoffman Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Anna M. Gordon

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence Gordon
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): July 13, 1885

8. AGE: Years: 60 | Months: 7 | Days: 14 | If less than one day: ##### hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Frank Peters
13. Birthplace: France

MOTHER
14. Maiden Name: Mary Paulis
15. Birthplace: U.S.A.

16 (a) Informant: Thomas F. Gordon (Son)
(b) Address: 2056 E. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/2/46 (month) (day) (year)
(c) Cemetery or crematory: Morelands Park
Location: Taylor Ave., Balto; Co

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (Date received by registrar) MAR 1 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27 1946 at 10:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Feb 28 1946, and that I last saw her alive on Feb 27 1946.

Immediate cause of death: Decompensating cardio-renal Valvular disease — Duration: 6 mos +

Due to: Cancer Uterus — 6 mos +

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: David Schneider M. D.

Address 1101 N Milton Ave Date signed 2-28-46

VS 150

Huntington Williams, M.D.

G37939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54 B

Registration No. G37939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5514 Edna Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5514 Edna Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OTTO ROBERT KLATT

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	212-03-0010

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Warneke Klatt
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Office Clerk - Ret.
11. Industry or business Henry Lauts & Co.

FATHER
12. Name Robert Klatt
13. Birthplace Germany

MOTHER
14. Maiden Name Lina Kreisel
15. Birthplace Germany

16 (a) Informant Mrs. Mary Klatt
(b) Address 5514 Edna Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-43 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) MAR 1 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1943, at 8.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940. to 1946.
and that I last saw h[illegible] alive on 2-25 1946.

Immediate cause of death: Broncho Aniumania — Duration 2 Days
Due to: Brain tumor — 18 Months
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation Sept. 1944
Major findings of operation: Malignant Tumor
of autopsy: Brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. W. Peake M. D.
Address 4508 Harford Rd Date signed 2-27-46

X

G37940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G37940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 N. Sricker Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER RHEUBOTTOM

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma B.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 28, 1877
8. AGE: Years 69 | Months - | Days 29 | If less than one day hr. min.
9. Birthplace Sykesville, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Rheubottom
13. Birthplace Sykesville, Md.

MOTHER
14. Maiden Name Louisa Williams
15. Birthplace Sykesville, Md.

16 (a) Informant Emma B. Rheubottom
(b) Address 1214 N. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Johnsville, Cemetery
Location Carroll Co. Md.

18 (a) Funeral director Mrs. George H. Holland.
(b) Address 1613 Druid Hill Ave.

MAR 1 - 1946 (Registered by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27-1946, at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20-1946, to 2-27-1946 and that I last saw him alive on 2-27-1946.

Immediate cause of death Cerebral Hemorrhage. — Duration 10 da.
Due to Chron. Myocarditis
Due to Chron Gastritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. R. Boyken M.D.
Address 1135 Gilmor Date signed 2/28/46

VS 150

G37941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G37941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 McCulloh Street
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgiana H. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1879

8. AGE: Years	Months	Days	If less than one day
67	5	26	hr. min.

9. Birthplace Rectortown, Va.
(Town, county, and state)
10. Usual Occupation Social Worker
11. Industry or business

FATHER
12. Name John Fields
13. Birthplace Rectortown, Va.

MOTHER
14. Maiden Name Edmonia DeNeal
15. Birthplace Rectortown, Va.

16 (a) Informant J. Weseley Austin
(b) Address 2419 Shannon Pl. S.E.-D.C.

17 (a) Removal (b) Date thereof 2-28-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Chester, Pa.

18 (a) Funeral director Mrs. Geo. H. Holland.
(b) Address 1621 Druid Hill Ave.

MAR 1 - 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1946, at 10 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to 2-25 1946
and that I last saw her alive on 2-25 1946

Immediate cause of death Hypertension Cardio Vascular Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Butler M.D.
Address 2033 Linden Ave. Date signed 3/1/46

VS 150

G37942 JL - 99582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G37942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bel Air, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spencer Nagle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	9	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Nagle
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof May 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cemetery
Location Bel Air Md

18 (a) Funeral director Dean & Foster
(b) Address Bel Air Md.

19 (a) Filed MAR 1 - 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1946 to Feb. 28 1946 and that I last saw h im alive on Feb. 28 1946

Immediate cause of death Coma

Due to Chronic leg ulceration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Haviland M. D.
Address B. C. H. Date signed 3/1/46

VS 150

G37943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G37943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6123 Sefton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6123 Sefton Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Florence Jackel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife William L.

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1887

8. AGE: Years 58 | Months 3 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Gustav Schmidt

13. Birthplace Balto.

MOTHER 14. Maiden Name Dorothea Kreider

15. Birthplace Balto.

16 (a) Informant Wm L. Jackel

(b) Address 6123 Sefton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem Co

Location City

18 (a) Funeral director Lilly & Funeral Home

(b) Address 2008 Aliceanna St

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

MAR 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946 at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945 to Feb 26 1946, and that I last saw h[illegible] alive on Feb 26 1946.

Immediate cause of death: Influenza Lobar Pneumonia and Cerebral Embolism — Duration: 2 Days

Due to

Due to

Other Conditions Rheumatic Fever — 12 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg

Address 2025 E North Ave Date signed 2/27/46 M. D.

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37944 (1310a)

Registered No. G37944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MINOR'S RECEIPT REQUIRED FOR BURIAL

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2049 Fleet St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2049 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Kefalos

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emma
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 5/11/1888

8. AGE: Years	Months	Days	If less than one day
57	9	15	hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Restauranteer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Emma Kefalos
(b) Address 2049 Fleet St 3/1/46

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 3/1/46
(c) Cemetery or crematory Cemetery
Location Greek - Balto Co.

18 (a) Funeral director Lambros Funeral Home
(b) Address 438-440 E. North Ave

19 MAR 1 - 1946 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946, at 6 36 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945, to 2/26 1946, and that I last saw h alive on 2/25 1946.

Immediate cause of death	Duration
Cardio-Vascular Renal Disease	7
Due to	
Due to	
Other Conditions Bronchiectasis Bronchial Asthma	2

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph D. Blum M.D.
Address 1206 E. Preston St Date signed 3/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37945 HB # 98551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G37945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Leagues J.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29th 1863

8. AGE: Years 82 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William League
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Thomson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 1st 1944 (month) (day) (year)
(c) Cemetery or crematory St Matthews
Location Odonnell St Ext

18 (a) Funeral director Leo G. Brook
(b) Address 1701-03 N Patterson Pk Ave

19 (a) MAR 1 1944 (Date rec'd) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28th 1944 at 10.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14th 19 44 to Feb. 28 19 44 and that I last saw h im alive on Feb. 28th 19 44

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions ASHD
fracture
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.

Address B. C. H. Date signed 2/23/44

X

G37946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37946 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor ID
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward Mc Creary (Creary)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Ida Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1861

8. AGE: Years	Months	Days	If less than one day
85	1	26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name John Mc Creary
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sarah Demuth
15. Birthplace Dayton Ohio

16 (a) Informant Little Sisters of the Poor,
(b) Address 1201 Valley Stre

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 4 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) [illegible] (b)
(Signature of registrar) Registrar

MAR 1 1946 Huntington Hillman, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1- 1946, at 8-10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-1- 1946, to Mch 1- 1946, and that I last saw him alive on Feb 28 1946.

Immediate cause of death	Duration
Edema of Lungs -	1 day.
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arterio Sclerosis -	5 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall - M. D.

Address 1631 E. North Av Date signed 3/1/46

G37947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 169

G37947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Beltsville, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Henry Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Construction

FATHER
12. Name Powell G. Pierce
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Tucker
15. Birthplace Md.

16 (a) Informant H. C. Gibson
(b) Address Springerville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2 1946 (month) (day) (year)
(c) Cemetery or crematory Union Cemetery
Location Bentonsville, Md.

18 (a) Funeral director Wm. Fitch Thomas
Address Laurel, Md.

19 (a) MAR 1 - 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1946, at 8 05 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Confluent Lobular Pneumonia traumatic, Fracture of Ribs, left.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/26/46 at P. G. Co. M.
(b) Where did injury occur? Beltsville, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by train

23. Signature Robert Lee Lichtenberger M.D. Medical Examiner
Date signed Feb 28 1946

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

037948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

037948 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3818 - 6th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3818 - 6th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Gottschalk

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1871

8. AGE: Years 74 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Kasimer Himmel

13. Birthplace Germany

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant Anna Williams

(b) Address 3818 - 6th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-1946 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location B. A. Co. Md.

18 (a) Funeral director Flynn & Flynn

(b) Address 426 Light St

MAR 1 - 1946

(Date rec'd by registrar) (Signature) Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1946, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943, to Feb 1946, and that I last saw h alive on 2/26 1946

Immediate cause of death central Hemorrhage

Due to hypertension and cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. W. Hunter M.D.

Address 302 Patapsco Av Date signed 2/27/46

VS 150

G37949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G37949 ✓ 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 Lawson St
(c) Hospital or institution: ✓ 46
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Lawson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Doran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Martin Doran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/1869

8. AGE: Years 76 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Burke
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes Murray
15. Birthplace Ireland

16 (a) Informant Mrs. Loretta Daly
(b) Address 1344 Lawson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave.

MAR 1 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1946, at 2.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1946, to Feb 26 1946, and that I last saw h-- alive on Feb 26 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arterial Hypertension	3 yrs
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Saunders M.D.

Address 436 E Fort ave Date signed 3/2/46

X

G37950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G37950 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~No.~~ 300 S. Exeter St.
(c) Hospital or institution: 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 S. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Felicino or Felix Carbonara

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	218-10-1147

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mariannina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1892

8. AGE: Years	Months	Days.	If less than one day
53	11		hr. min.

9. Birthplace Nusco Italy
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Giovanni Carbonara
13. Birthplace Italy

MOTHER
14. Maiden Name Raffaela Grieco
15. Birthplace Italy

16 (a) Informant Mariannina Carbonara (Wife)
(b) Address 300 S. Exeter St.

17 (a) Burial (b) Date thereof March 2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 MAR 1 - 1946 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1946, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from N-27 1945, to 2-27 1946 and that I last saw h~~im~~ alive on 2-20 1946

Immediate cause of death	Duration
Incurable carcinoma of	18 mo. abt
Due to Stomach pyloric obstruction,	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Dynacci M. D.
Address medical arts Bldg Date signed

G37951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G37951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Oxford St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bruce Fleming

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-1910

8. AGE: Years 35 | Months 4 5 | Days 1 | If less than one day hr. min.

9. Birthplace Cedartown Ga.
(Town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER — 12. Name Timothy Fleming
13. Birthplace Ga

MOTHER — 14. Maiden Name Della Dykes
15. Birthplace Ga

16 (a) Informant Timothy Fleming
(b) Address 519 Oxford St.

17 (a) Burial (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pepperton Ga
Location Cedartown Ga

18 (a) Funeral director Charles L Cooper
(b) Address 512 Carrollton Ave.

19 (a) Filed by Registrar Huntington Williams, M.D. Registrar

MAR 1 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1946, at 7:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound of chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 27, 1946 M.S.T.
(b) Where did injury occur? Penna. Ave. & Dolphin
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shooting

23. Signature Benedict Skowronski M.D.
Medical Examiner.
Date signed 2-27-46

X

G37952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

G37952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp - 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Orchard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Mr. Bob Roberts
(b) Address Dillon, S.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-46 (month) (day) (year)
(c) Cemetery or crematory Dillon, South Carolina
Location

18 (a) Funeral director Adolphus Halsted
(b) Address 9 W Druid Hill Ave

19 (a) (Date received by registrar) (b) Registrar

MAR 1 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946, at 10:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed skull

Due to Blunt instrument.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 24, 1946 M.
(b) Where did injury occur? 509 Orchard St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Blunt instrument.

23. Signature Benedict Skotarelic M.D. Medical Examiner.
Date signed 2-25-46

X

G37953

479550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G37953

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County.....
(c) City or town Newport News.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5010 Huntington Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Nelson Hinton Daughtrey.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-13-06

8. AGE: Years	Months	Days	If less than one day
39.	7	15	hr. min.

9. Birthplace Newport News Va.
(Town, county, and state)
10. Usual Occupation Wreaftsman
11. Industry or business

FATHER
12. Name Wesley J. Daughtrey
13. Birthplace Va.

MOTHER
14. Maiden Name Jennie Richardson
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof March 1 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Newport News
Location Old Point Cemetery Va.

18 (a) Funeral director John C Miller Jr
(b) Address 2435 E Olney St

19 (a) (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1946, at 11. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1945 to Feb 28 1946 and that I last saw him alive on Feb 28 1946.

Immediate cause of death	Duration
Undetermined	
Due to Post-Operative	
following Pre-frontal	
Due to Lobotomy	over
Other Conditions Generalized	
Carcinomatosis.	

(Tuberculosis, syphilis, cancer, etc., state whether a contributory cause)

Date of operation Feb 28 1946

Major findings of operation.....

of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature James E. J. Hobbins

Address Johns Hopkins Hospital Date signed Mar 1 1946

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12/a

637954 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Edmondson Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4601 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME John M. Welsh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Gertrude F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4, 1882

8. AGE: Years	Months	Days	If less than one day
63.	11	25 28	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Builder
11. Industry or business —

FATHER
12. Name Patrick Welsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kavanaugh
15. Birthplace Ireland

16 (a) Informant Mrs Gertrude F. Welsh
(b) Address 4601 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John E. Conway & Son
(b) Address 901-03 Fulton Ave

19 (a) (Date received by registrar) (b) Thurlington Williams M.D. (Registrar)

MAR 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/1946 at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to Mar. 1 1946, and that I last saw h[illegible] alive on Mar. 1 1946.

Immediate cause of death	Duration
Uremia	3 wks.
Due to Nephrosclerosis	6 mos.
Due to Arteriosclerosis	
Other Conditions Arteriosclerosis	15 yrs+

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation .....
.....
of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Herbert Goldstone M. D.
Address 743 Linden Ave. Date signed Mar 1, 1946

G37955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

G37955 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 14
(d) Length of stay in hospital or institution (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT ALEXANDER Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Lillian L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 8, 1903

8. AGE: Years	Months	Days	If less than one day
42	8	20	hr. min.

9. Birthplace BELFAST, IRELAND. (Town, county, and state)
10. Usual Occupation Steam Jitter
11. Industry or business

FATHER
12. Name Thomas Pt. Moore
13. Birthplace Belfast, Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant THOMAS H. McCURDY
(b) Address 300 E. MAIN ST

17 (a) SHIPPING. (Burial, cremation, or removal) (b) Date thereof 3-1-46 (month) (day) (year)
(c) Cemetery or crematory HUMMELSTOWN
Location HUMMELSTOWN, PA.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 (a) (by registrar) (b) Registrar

MAR 1 - 1946

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Deep laceration of throat involving large vessels
Due to and trachea.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 28, 1946 M.
(b) Where did injury occur? 1430 Linden Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Slashed throat with razor

23. Signature Benedict Skitarelic M.D.
Date signed 2-28-46 Medical Examiner.

X

G37956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G37956 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 361 W. Glendale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 361 W. Glendale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Agnes (Nellie) Kell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife H. Clarence Kell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 - 1875

8. AGE: Years	Months	Days	If less than one day
71	1	7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Cecilia Gilchrist
15. Birthplace Ireland

16 (a) Informant H. Clarence Kell
(b) Address 361 W. Glendale Ave

17 (a) Burial (b) Date thereof 3-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Lorenz Byers
(b) Address 5005 Park Heights Ave

19 (a) Date received MAR 1 - 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26, 1946, at 10:48 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Feb 26 1946, and that I last saw h[er] alive on Nov 25 1946

Immediate cause of death	Duration
(a) Coronary Occlusion	10 days
Due to (b) Angina Pectoris	
Due to (c) Myocarditis	
Other Conditions — Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Mills
Address 5216 Park Ave Date signed Mar 1 46

G37957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G37957 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age, especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 South Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kontoura or Kontouras

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Gust Kontouras
13. Birthplace Greece

MOTHER
14. Maiden Name Theodora Dinis
15. Birthplace Greece

16 (a) Informant Anna (wife)
(b) Address 1624 Fleet St

17 (a) Burial (b) Date thereof 3/2/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Greek
Location Windsor Mill Rd

18 (a) Funeral director Selby & Zeiler
(b) Address 402 S Broadway

19 (a) (Date rec'd by registrar) MAR 1 1946 (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1946, at 10 05 A.M.

21. I certify that I took charge of the remains described above, held an INSPECTION (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull, Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5

(a) Date of injury 2-28-46 at 9 A.M.
(b) Where did injury occur? Curtis Bay Coal Piers
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from scaffold

23. Signature Roland Lee Gratacap M.D.
Medical Examiner.
Date signed Feb. 28 1946

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G379538 ✓ G37953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Summe or Josephine Somme

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1869

8. AGE: Years	Months	Days	If less than one day
76	5	5	hr. min.

9. Birthplace Norway
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ben Peterson
13. Birthplace Norway

MOTHER
14. Maiden Name Anna
15. Birthplace Norway

16 (a) Informant B. C. H. records
(b) Address 4940 Eastern Ave.

17 (a) 3/7/46 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory David Hart
Location Harmon Hill Rd

18 (a) Funeral director Kelly & Zeluck
(b) Address 403 S. Wolfe St

19 (a) (b)
(Date rec'd by registrar) MAR 1 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1946 to Feb. 28 1946 and that I last saw her alive on Feb. 28 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B. C. H. Date signed 3/4/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37959

TN. 99470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G37959 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Thames St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Kowalski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30th ? 1884

8. AGE: Years 61 ? | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kowalski (D
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Mrokki (D
15. Birthplace Poeland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Valley & Baltimore

18 (a) Funeral director 1603 E. North Ave
(b) Address Edenson Hall Rd

MAR 1 1946 (a) (b)
(Filed by registrar) Registrar

Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23rd, 1946 at 2.P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23rd 19 46 to Feb 23 19 46 and that I last saw him alive on Feb 23rd 1946

Immediate cause of death: Cardiac failure — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions, Prostatic hypertrophy and uremia retention
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy none obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 3/1/46

G37960

BALTIMORE CITY HEALTH DEPARTMENT

HB # 99543 CERTIFICATE OF DEATH 94a (over)

G37960 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Lehigh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Walters also known as Hannah Heath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Frank Walters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1876

8. AGE: Years	Months	Days	If less than one day
69 68	8 6	8 11	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Gabel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Fredel
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baston Ave 208

18 (a) Funeral director Lilly & Zade
(b) Address 403 E. Fayette St

MAR 5 - 1946 (b)
(Date filed by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946 at 11:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26, 1946 to Feb. 28 1946 and that I last saw h~~im~~er alive on Feb. 28, 1946

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 3/1/46

VS 150

G37961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

G37961 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 S.COLLINGTON AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S.COLLINGTON AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET M.BRUNNER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 28 1862

8. AGE: Years 83 | Months 6 | Days 27 29 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JOSEPH BRUNNER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET WERNER
15. Birthplace GERMANY

16 (a) Informant FRANK BRUNNER (BROTHER)
(b) Address 106 S.COLLINGTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 2/46 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S.WOLFE ST.

MAR 2 1946 (Date received by registrar) (b) Registrar

VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH FEB. 27 1946, at 4/30M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11/46 19 to Feb 27 1946.
and that I last saw h[illegible] alive on Feb. 27 1946.

Immediate cause of death: Cerebral hemorrhage — Duration: 2 days
Due to: Arterio - sclerotic cardio vascular disease with — Duration: years
Due to: hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M. D.
Address 404 S. Pat. Pk. Ave Date signed 2/28/46

X

G37962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G37962 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmont
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) All 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Rosslyn ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3 (a) FULL NAME Mrs Sydney W. Richardson Sydney W. Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Rev. C. Herbert Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? About 1866

8. AGE: Years	Months	Days	If less than one day
Abt 79			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph R. Wheeler
13. Birthplace Virginia

MOTHER
14. Maiden Name Julia Hanton
15. Birthplace Virginia

16 (a) Informant Millard Wheeler
(b) Address 4500 Carlway Balto 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Glenwood Cemetery
Location Washington, D. C.

18 (a) Funeral director Miller Lamborn
(b) Address 4510 Liberty Heights Ave.

19 (a) (b)
Date rec'd by registrar MAR 1 - 1946 Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946, to 3-1 1946, and that I last saw h.. alive on 3-1 1946.

Immediate cause of death	Duration
Cerebro Vascular accident	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert D. Pratt Peck M. D.
Address Church Home-Hosp Date signed 3-1-46

X

G37963

BALTIMORE CITY HEALTH DEPARTMENT X G37963 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 E. Lexington St.
(c) Hospital or institution: Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Balto. Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 Tennent Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bentz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary Bentz

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1882

8. AGE: Years 63 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Bentz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Burke
15. Birthplace Md.

16 (a) Informant Mrs. Sarah Bentz
(b) Address 310 Tennent ave.

17 (a) Burial (b) Date thereof 3-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md.

18 (a) Funeral director A. Bankard & Son
(b) Address Westminster, Md.

19 (a) (Date received by Registrar) MAR 1 1946 (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1946, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1946 to 3-1 1946, and that I last saw him alive on 3-1 1946.

Immediate cause of death	Duration
Broncho Pneumonia	16 days
Due to (Coronary occlusion)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold W. Lemmon M.D.

Address 5-6-69 Date signed 3-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G37964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G37964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 Notre Dame Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 Notre Dame Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Irvin E. Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nona Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1884

8. AGE: Years	Months	Days	If less than one day
61	4	27	hr. min.

9. Birthplace Westfield Indiana
(Town, county, and state)

10. Usual Occupation Self

11. Industry or business Real Estate

FATHER
12. Name Harris E. Butler
13. Birthplace Pa.

MOTHER
14. Maiden Name Rebecca Uncapher
15. Birthplace Pa.

16 (a) Informant Nona Butler
(b) Address 435 Notre Dame Ave.

17 (a) Burial (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Presbyterian Church
Location Churchville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAR 2 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28th 1946, at 9.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to 28 Feb 1946, and that I last saw him alive on 28 Feb 1946.

Immediate cause of death	Duration
Hypertension - Cardio Vascular Renal	2 yrs.
Due to Uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd L. Saylor M. D.
Address 3902 Greenmount Date signed 3/4/46

VS 150

G37965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

G37965 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 N. Port st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RADKE, MRS. IVY (IVY C. RADTKE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, ~~widowed, or~~ divorced: Married

6 (b) Name of husband ~~or wife~~: Albert Radtke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14th 1914

8. AGE: Years 31 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Nicholas Diehl
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lilly Louise (Unknown)
15. Birthplace Md.

16. (a) Informant Albert R. Radtke
(b) Address 1623 N. Port st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Bal. St.

19 (a) MAR 2 - 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1- 1946 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13-1946 to 3-1-1946 and that I last saw h[illegible] alive on 3-1-1946.

	Duration
Immediate cause of death Respiratory failure	
Due to Pulmonary Oedema	
Due to Aplastic Anaemia, cause undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hosp. Date signed 3-1-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

G37966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G37966

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) JC

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 62 E High St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Gerry Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mrs J G Moore

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.) Feb 10 1884

8. AGE: Years 62 | Months 0 | Days [illegible] | If less than one day: 19 hr. 21 min.

9. Birthplace Moorsville Md
(Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER
12. Name Alexander Moore
13. Birthplace Md

MOTHER
14. Maiden Name Alma McCarten
15. Birthplace Md

16 (a) Informant —
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md

18 (a) Funeral director C M Deter & Sons
(b) Address Hagerstown Md

MAR 2 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1946, at 5 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946 to 3/1 1946, and that I last saw h/m alive on 3/1 1946

Immediate cause of death	Duration
Cerebro Vascular Accident	6 hrs
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex O'Neill Jr

Address Mercy Date signed 3/1

G37967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 164a

G37967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Hanover Sts
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 N. Fulton Ave
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME James Gilmore Keatts

3 (b) If married, name wife: None

3 (c) Social Security Account No. 213-03-7239

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Nellie Keatts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 28 1895

8. AGE: Years	Months	Days	If less than one day
50	8	13	hr. min.

9. Birthplace: Rockingham, N.C.
(Town, county and state)

10. Usual Occupation: Linotype Operator
11. Industry or business: Daily Record

FATHER
12. Name: Richard Keatts
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Betty Preston
15. Birthplace: N.C.

16. (a) Informant: Mrs. Nellie Keatts
(b) Address: 923 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-46 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2446 Frederick Ave.

19 (a) MAR 2 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at 7:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 1, 1946 8 P.M.
(b) Where did injury occur? Northwest District Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
Means of injury: Hung himself in jail

23. Signature: Benedict Skitarelic M.D.
Medical Examiner.
Date signed 3-1-46

VS 151

G37968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G37968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2536 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Frederick Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph Eichner

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-03-0137

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ethel May Eichner
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) March 5, 1908

8. AGE: Years 37 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Sheet Metal Worker
11. Industry or business: Glenn L. Martin

FATHER
12. Name: Matthias Eichner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louise Pfalzer
15. Birthplace: Germany

16 (a) Informant: Ethel May Eichner
(b) Address: 2536 Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-46 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: Henry L. Lehnert
(b) Address: 2101 Frederick Ave.

19 (Date rec'd by registrar) MAR 2 - 1946 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Benedict Skotarelis M.D.
Medical Examiner.
Date signed 2-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G37969 Registered No. 2678

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished or supplied. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie E. Thompson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	married

6 (b) Name of husband or wife John W. Thompson
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 5-15-1893

8. AGE: Years	Months	Days	If less than one day
52	9	13	hr. min.

9. Birthplace Lewistown N. Carolina (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business Own Home

FATHER
12. Name Eli Clark
13. Birthplace North Carolina

MOTHER
14. Maiden Name Eliza Williams
15. Birthplace North Carolina

16 (a) Informant John W. Thompson
(b) Address 1023 Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 MAR 2 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28-1946; at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28-1946 to 2-28-1946 and that I last saw her alive on 2-28-1946

Immediate cause of death	Duration
Cerebral hemorrhage	9 hours
Due to Hypertension and arterio Sclerosis	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders MD M. D.
Address 1029 N. Stricker Date signed 3-1-46

VS 150

X

G37970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. G37970

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland E
(b) Street address 43 Kennietta St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 E. Kennietta St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Louise McClean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Albert

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) December 24

8. AGE: Years	Months	Days	If less than one day
79	2	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Karl L.
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Kaulke
15. Birthplace Germany

16 (a) Informant Mr Albert McClean
(b) Address 3704 Normandy Ave

17 (a) Burial (b) Date thereof 3/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director John F Denny Inc
(b) Address 705 Light St

MAR 2 - 1946
(Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to February 1946 and that I last saw h alive on February 2 1946.

	Duration
Immediate cause of death Coronary Thrombosis	2 mos.
Due to Chronic Glomerulonephritis	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Macleod M.D.
Address 129 Millbank Date signed 3/2/46
M. D.

VS 150

3800 Ed. Ave
G37971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G37971
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address COLDSPRING LANE
(c) Hospital or institution:
COLDSPRING NURSING HOME 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO. 11
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3137 FAIT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE DOSCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife SARAH DOSCH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15-1871

8. AGE: Years	Months	Days	If less than one day
74	6	12	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name ANDREW DOSCH
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY SAUTERS
15. Birthplace GERMANY

16 (a) Informant MARY RIEMAN (DAUGHTER)
(b) Address 3137 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 2/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Leilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) [illegible] (b)
MAR 2 1946 Washington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 27 1946 at 10p M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 1 1946 to FEB 27 1946, and that I last saw him alive on FEB 26 1946.

Immediate cause of death	Duration
PULMONARY HEMORRHAGE	-6 hrs
Due to ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Klemm M. D.
Address 3803 Edmondson Ave Date signed March 1, 1946

X

G37972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G37972

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oakland & Layton 16
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 W. Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry O. Weidenhammer

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6. (b) Name of husband or wife Lillian Weidenhammer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1890

8. AGE: Years	Months	Days	If less than one day
55	11	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Edward J. Weidenhammer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M. Nicholas
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Lillian Weidenhammer
(b) Address 2313 W. Mosher St.

17 (a) Burial (b) Date thereof 3/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 2 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1946, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1946, to 2-28 1946, and that I last saw h/ alive on 2-28 1946

Immediate cause of death	Duration
Cardiac failure	
Pulmonary edema	
Arteriosclerotic Cardiovascular	
Due to Disease	
Generalized arteriosclerosis	
Due to Extensive cerebral & cerebellar	
Causes of Hemiplegia, Aphasia	
Other Conditions Causes of Hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Luther Baldwin M. D.
Address WB Jt Date signed 2-28-46

VS 150

G37973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G37973

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Titter

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harriett B. Titter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1862

8. AGE: Years 83 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace: Cecil County, Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Isaac Titter
13. Birthplace: Delaware

MOTHER
14. Maiden Name: Eliza Anderson
15. Birthplace: Maryland

16 (a) Informant: Mr. Milton M. Titter
(b) Address: Chesapeake City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory: Bethel Cemetery
Location: Cecil County, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 2 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1946, to 3/1 1946, and that I last saw him alive on 2/28 1946.

Immediate cause of death Pneumonia — Duration 48 hrs

Due to Cardiac failure — 72 hrs

Due to — over

Other Conditions Uremia — 8 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent de P. Fitzpatrick Jr

Address Mercy Hosp. Date signed 3/4/46

637974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

637974 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3317 Rueckert Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Rueckert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE E. BAKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Eugene N. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1871

8. AGE: Years	Months	Days	If less than one day
74	9	21	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Edwin Chance
13. Birthplace Chester, Pa.

MOTHER
14. Maiden Name Annie Earnshaw
15. Birthplace Harpers Ferry, W. Va.

16 (a) Informant Mrs. Georgia Nickles
(b) Address 3317 Rueckert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by registrar MAR 2 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946, at 4:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1934 to 3-1 1946 and that I last saw her alive on 2-25 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Peaks M. D.
Address 4518 Hayford Rd Date signed 3-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37975 39546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

Registered No. G37975

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Kimley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva May Wilkie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Wilkie (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16th 1890

8. AGE: Years	Months	Days	If less than one day
55	9	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John M. Corkan
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Augusta Davis
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Parkwood
Location Taylor Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 2 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28th 1946 19 , at 8.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26th 19 46 to Feb. 28th 46 and that I last saw her alive on Feb. 28 19 46

Immediate cause of death Acute yellow atrophy of the liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes abstr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Bowland M. D.
Address A.C.H. Date signed 2/28/46

G37976

HEALTH DEPARTMENT—CITY OF BALTIMORE

G37976

CERTIFICATE OF DEATH ✓ 46 B

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact st OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 736 Carrollton Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME John E. DeShields 16 1 — If U. S. Veteran specify WAR

(a) Residence: No. 736 Carrollton Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	col.	Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Belle R.

6. DATE OF BIRTH (month, day, year) July 7-1882

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	7	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Storekeeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Joseph DeShields

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Mary Gray

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Arnetta DeShields
(Address) 736 N. Carrollton Ave.

18. BURIAL, CREMATION, OR REMOVAL
Columbus Memorial Park Date 3-3- 1946

19. UNDERTAKER Wm. G. A. Holland
(Address) 631 Druid Hill Ave.

20. Filed MAR 2 - 1946 19 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 24, 1946

22. I HEREBY CERTIFY, That I attended deceased from 11-10-45, 1945, to 2-24, 1946

I last saw ~~him~~ alive on Feb 24, 1946 Death is said to have occurred on the date stated above, at 2:55 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	2-24-46
Other contributory causes of importance: Carcinoma of Stomach	

Was an operation performed? Yes Date of Dec 15 1945

For what disease or injury? Carcinoma of Stomach

Name of operation Resection of Stomach

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) M Ewalan M. D.

(Address) 803 N Fremont Ave

G37977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G37977

Dec 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Argyle Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Betty Singleton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1942

8. AGE: Years 3 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Henrietta Singleton
15. Birthplace Md

16 (a) Informant Lillie Jones
(b) Address 1617 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Presstman St

19 (a) (Date received by Registrar) Huntington Williams, M.D. Registrar

MAR 2 — 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1946 at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to extensive 3rd degree burns.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-28-46 at 14/2 9 15 A.M.
(b) Where did injury occur? 1617 Argyle Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Oil stove ignited

D. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 28 1946

X

G37978 Orig Cert Surface G-4296 BALTIMORE CITY HEALTH DEPARTMENT 84a Registered No. G37978

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD + CALVERT STS.
(c) Hospital or institution: THE UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Md.
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Wellington Rd. City 12
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Glenn Cromwell Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/27/46

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Mr. Charles Glenn Cromwell
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorothy Vogel
15. Birthplace Maryland

16 (a) Informant ~~Husband~~ Father
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Av- Ballola

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (E. F. MOWEN SUC.) 100 N. HOWARD AVENUE

19 (a) (b)
MAR 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/1946 at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1946 to 3/1/1946 and that I last saw h. alive on 3/1/1946.

Immediate cause of death	Duration
Asphyxia Neonatorum	
Due to Mongoloid Idiocy	
Due to	
Other Conditions Congenital Cataracts bilateral	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm W. Hodges M. D.
Address Union Mem Hosp Date signed 3/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. G37979
1200 Baltimore Blvd

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G37979

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie M Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married, widowed, or divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/7/1876

8. AGE: Years 69 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas C Grimm
13. Birthplace Balto Md

MOTHER
14. Maiden Name Emma A Kaufman
15. Birthplace Balto Md

16 (a) Informant Thomas C Grimm
(b) Address 3223 Brighton ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd

18 (a) Funeral director Edw Loudon
(b) Address 2359 Wash Blvd

19 (a) (Signature of local registrar) (b) Registered MAR 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1945 to March 1 1946, and that I last saw h[illegible] alive on Feb. 28 1946

	Duration
Immediate cause of death	
Coronary Thrombosis	few hrs
Due to Cardiovascular Disease	6-7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Bauerman Ford M. D.
Address 2200 Garrison Blvd Date signed 3/2/46

637980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

637980 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 834 Vine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Vine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Earnest Richardson
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec. 20 1892

8. AGE: Years	Months	Days	If less than one day
53	2	6	hr. min.

9. Birthplace Winsborough S C
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aaron Ashford
13. Birthplace Winsborough S C

MOTHER
14. Maiden Name Caroline Harrison
15. Birthplace Winsborough S C

16 (a) Informant Earnest Richardson
(b) Address 834 Vine St

17 (a) Burial (b) Date thereof March 4, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 MAR 2 - 1946 Katie R. Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946 at 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1946 to 2-26 1946 and that I last saw h[illegible] alive on 2-26 1946

Immediate cause of death Hypertensive Cardio Vascular Disease — Duration 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M.D.
Address 534 Dolphin St Coroner's Physician
2-26-46

VS-150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G37981

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Lexington St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lelbie Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife John Henry Hooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 1894

8. AGE: Years	Months	Days	If less than one day
51	9	10	hr. min.

9. Birthplace Essex Co. Virginia
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Own Home

FATHER
12. Name Wallace Oakley
13. Birthplace Essex Co. Virginia

MOTHER
14. Maiden Name Rosa Lee Young
15. Birthplace Essex Co. Va

16 (a) Informant Florence Johnson
(b) Address 1605 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8, 46 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) MAR 2 1946 (b) Huntington Ave Millinocket, Me

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1946; at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1946 to 2-28 1946, and that I last saw h alive on 2-28 1946.

Immediate cause of death	Duration
Chronic Nephritis	yrs mos hrs
Due to	
Due to	
Other Conditions Impaerdisto	yrs mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frank A. Saunders M. D.
Address 1029 N. Strieker Date signed 3-1-46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G37982

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Robert Riana Holt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1898

8. AGE: Years	Months	Days	If less than one day
47	6 9	10	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Oliver Holt
13. Birthplace Md.

MOTHER
14. Maiden Name Sally Smith
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave.

19 (a) (b)
(Date received by local registrar) Huntington Williams M.D.
MAR 2 1946

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH March 1, 1946; at 10:55M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26, 1946 to Mar. 1, 1946 and that I last saw him alive on Mar. 1, 1946

Immediate cause of death Pulmonary hemorrhage — Duration

Due to Chronic pulmonary tuberculosis

Due to

Other Conditions Peptic ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M.D.
Address D.C.H. Date signed 3/6/46

G37983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G37983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2929 Odonnell St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 O'Donnell St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Wagner Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Michael Wagner

13. Birthplace Poland

MOTHER 14. Maiden Name Mary Rembeck

15. Birthplace Poland

16 (a) Informant Elizabeth Wagner

(b) Address 2924 O. Donnell St

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 (month) 4 (day) 46 (year)

(c) Cemetery or crematory Dept of Recreation Mary

Location Herring Run Park

18 (a) Funeral director Stephen F Hughes

(b) Address 1000 S. Kenwood Ave INC.

Filed MAR 5 1946 by Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1946, at 9:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Myocardial fibrosis

Due to

Other Conditions Pulmonary Edema.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Skotarelic M.D. (Medical Examiner.)

Date signed 2-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G37984

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 328 E. 22nd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 328 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LYDIA C. FEESER

3 (b) If veteran, name war	3 (c) Social Security Account No.
-------	-----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas D. Feeser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, (1862)

8. AGE: Years	Months	Days	If less than one day
83	7	4	hr. min.

9. Birthplace Littlestown, Pa.
(Town, county, and state)
10. Usual Occupation ---
11. Industry or business

FATHER
12. Name ? Young
13. Birthplace Germany

MOTHER
14. Maiden Name Lydia Unger
15. Birthplace Pa.

16 (a) Informant Mr. LeRoy Feeser
(b) Address 2315 Chelsea Terrace

17 (a) Burial (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Littlestown, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS, INC.
(b) Address North & Pa. Aves.

19 MAR 3 - 1946 Huntington Williams, M.D.
(Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to March 2 1946 and that I last saw h.h. alive on March 1 1946.

Immediate cause of death: Carcinoma Cardiopl. Duration: Years
Due to: Carcinoma of Left Breast Years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert M. Foster M.D.
Address 2424 St. Paul Date signed March 2-46

VS 150

G37985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G37985

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Oakhurst Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Robinetta Stewart

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Howard R. Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1886

8. AGE: Years	Months	Days	If less than one day
59 ~~yrs~~	10	6	hr. min.

9. Birthplace Hedgesville, W. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jeremiah R. Pardew
13. Birthplace Bedford Co, Pa.

MOTHER
14. Maiden Name Ida Fauk
15. Birthplace Unknown

16 (a) Informant Mr. Paul Pardew
(b) Address 3501 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS, INC.
(b) Address North & Penna. Aves.

19 MAR 3 - 1946 Huntington Williams, M.D.
(Date received by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION 30

20. DATE OF DEATH March 1, 1946, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon monoxide poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1-46 at M.
(b) Where did injury occur? 1207 Oakhurst Place
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation of illuminating gas

23. Signature Benedict Bettarelli M.D. Medical Examiner.
Date signed 3-2-46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G37986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 100a

G37986 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1352 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Koons

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Koons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1882

8. AGE: Years	Months	Days	If less than one day
63	10	3	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Practical Nurse
11. Industry or business

FATHER
12. Name John Jacob Shipley
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Louise Gaver
15. Birthplace Frederick, Md.

16 (a) Informant Miss Kathryn E. Reitz
(b) Address 3756 Dolfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 3 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to Varicose Veins of leg (Left).

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Petarelis M.D. Medical Examiner.
Date signed

G37987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G37987

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 Silver Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Silver Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3.(a) FULL NAME EVA C. STARKEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Sig. Starkey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1862

8. AGE: Years	Months	Days	If less than one day
83	3	20	hr. min.

9. Birthplace Lebanon, Ohio
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel E. Hollingshead
13. Birthplace Ohio

MOTHER
14. Maiden Name Lydia Beller
15. Birthplace Ohio

16 (a) Informant Mrs. De Rose McGreevy
(b) Address 2810 Silver Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed MAR 2 - 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1946; at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1946, to Feb 28 1946
and that I last saw h[illegible] alive on Feb 28 1946.

Immediate cause of death	Duration
Myocarditis	
Due to Cardio vascular renal disease	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4710 Liberty Hts Date signed M. D. 3/1/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37388 ✓ G37388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3333 N.Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 N.Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eleanor M.Tapscott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William H.Tapscott
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec 13 1885

8. AGE: Years	Months	Days	If less than one day
60	2	16	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name James M.O'Neill
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Eleanor T.Ruth
15. Birthplace Baltimore Md

16 (a) Informant William H.Tapscott
(b) Address 3333 N.Charles St

17 (a) Burial (b) Date thereof Mar. 5 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry N. Amacost
(Address) 4804 Ridgewood Ave.

19 (a) MAR 3 1946 Huntington Williams, M.D.
(Date rec'd by registrar)

MAR 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 17 1939 to March 1 1946, and that I last saw h alive on March 1 1946.

Immediate cause of death	Duration
Apoplexy - Cerebral -	3 hours
Due to Arteriosclerosis	
Hypertensive Cardio-Renal Disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Buechler M. D.
Address 1801 E. Fayette St Date signed 3/7/46

X

G37989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G37989 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 N. Charles St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Faye Zelda De Board

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17-1928

8. AGE: Years	Months	Days	If less than one day
17	2	16	hr. min.

9. Birthplace Oklahoma
(Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER
12. Name Marion De Board
13. Birthplace Missouri

MOTHER
14. Maiden Name Alta Mae Sweeten
15. Birthplace Arkansas

16 (a) Informant Mercy Hospital Records
(b) Address Saratoga & Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)

(c) Cemetery or crematory
Location Henrietta, Oklahoma

18 (a) Funeral director H. W. Meamber
(b) Address 805 N. Calvert St

19 (a) MAR 8 1946 (Date registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1946, to Mar 2 1946 and that I last saw h[illegible] alive on Mar 2 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Rheumatic heart disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Roy Snyder M.D.
Address Mercy Hosp Date signed 3/5/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G37990 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Hilldale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Malin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Selig
13. Birthplace Russia

MOTHER 14. Maiden Name Faga
15. Birthplace Russia

16 (a) Informant Ida Malin
(b) Address 2808 Hilldale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philip Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) (Date received by registrar) (b) Registrar

MAR 3 - 1946

VS 150

Hunter to Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946, at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945, to March 2 1946, and that I last saw h/his alive on March 2 1946.

	Duration
Immediate cause of death Cardiac - Respiratory Failure	
Due to Coronary Sclerosis	
Due to	
Other Conditions Cardiac Failure Diabetes Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H W Hirschmann M.D.

Address Sinai Hospital Date signed 3/7/46

Hirschman

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G37991 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts.

(c) Hospital or institution: Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3203 Carlisle Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/46

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Siegmund Katz

13. Birthplace Balto

MOTHER 14. Maiden Name Dorothy Schapiro

15. Birthplace Balto

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-46 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Phila Rd & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) Huntington Williams, M.D. (Registrar)

(b) Date rec'd by registrar 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2 1946 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1946, to 3-2 1946 and that I last saw her alive on 3-2 1946.

	Duration
Immediate cause of death Pneumonia	
Bilateral Lobular	
Due to Aspiration	
Due to Possible Congenital atresia of Esophagus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia and Atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles L. Butler M. D.

Address Univ. Hospital Date signed 3-2-46

G37992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G37992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Belvedere Ave

(c) Hospital or institution: Aged Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. Greenspring Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MORRIS WURTZBURGER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Not Known

13. Birthplace Russia

MOTHER

14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-46 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Ferman Hill Rd.

18 (a) Funeral director Jack Lewis Inc

(b) Address 9439 E. Balto St

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MAR 3 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1941 to 3-2 1946 and that I last saw h[illegible] alive on 3-2 1946

Immediate cause of death Cerebral hemorrage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund Penn M. D.

Address Govdale Date signed 3-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G37993 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Hall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sophia C. Huber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry Huber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/87

8. AGE: Years 69 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Damer
15. Birthplace Baltimore

16 (a) Informant Mr Henry Huber
(b) Address 1236 Hall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/46. (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Russin Highway

18 (a) Funeral director J. J. Talley Sons
(b) Address 231 Light St.,

19. 1946 Huntington for Pittsburgh, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946 to March 1 1946, and that I last saw Dr. alive on Feb 28 1946.

Immediate cause of death	Duration
Cerebral Apoplexy.	
Due to	
Due to	
Other Conditions Arteriosclerosis, Hypertension, Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian G. Salvemini M.D.
Address 1337 S. Charles St. Date signed 3/2/46

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G37994 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Bayo St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Bayo (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Steele

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-7722

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Catherine Reilly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/15/1882

8. AGE: Years	Months	Days	If less than one day
63	9	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Nat. Enamel Stamping

FATHER
12. Name Geo Steele
13. Birthplace Ga

MOTHER
14. Maiden Name Mary Ewen
15. Birthplace Ga

16 (a) Informant Mrs J R Steele
(b) Address 1721 Bayo St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Reisterstown Highway

18 (a) Funeral director J. J. Reilly Sons
(b) Address 1316 Light St.

19 (a) 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946, at 3a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946 to March 1 1946 and that I last saw h alive on Feb 26 1946

Immediate cause of death	Duration
Cardiac Thrombosis	1 mo
Due to Chronic Rheumatism	3 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 1279 Fulton Ave Date signed 3/4/46

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G37995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G37995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 N. Ellwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Ellwood ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julian Piorunski

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Katherine Piorunski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1867

8. AGE: Years 78 | Months 8 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Joseph Piorunski
13. Birthplace Poland

MOTHER
14. Maiden Name Senkanowa
15. Birthplace Poland

16 (a) Informant Mrs Pauline Keller
(b) Address 610 N. Ellwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

Registered (Date) 3rd 1946 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1946, at 2.4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Feb. 28 1946 and that I last saw h[illegible] alive on Feb. 27 1946.

Immediate cause of death: Ca of Stomach (carcinoma) metastasis & Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 2579 Fenton Ave. Date signed M. D. 3/4/46

X

G37996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G37996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4616 Rokeby Road (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Schwenke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife.....
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 2/18/1946
8. AGE: Years | Months | Days: 8 | If less than one day ..... hr. ..... min.
9. Birthplace Balto (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Eugene Schwenke
13. Birthplace Baltimore

MOTHER
14. Maiden Name Aleta Paff
15. Birthplace Scranton Pa

16 (a) Informant Mrs Henry Reidt
(b) Address 4616 Rokeby Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 4 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Catonsville

18 (a) Funeral director Wellwood Funeral Home
(b) Address 2008 Pennsylvania Ave, Huntingdon Pittsburgh, Pa

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAR 3 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1946, at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1946, to 2-26 1946, and that I last saw him alive on 2-26 1946

Immediate cause of death Cerebral Hemorrhage — Duration 3 hrs.

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 2-26-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 24574 G37997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G37997 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 - 6 - 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Kaies

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Cleota (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1880

8. AGE: Years	Months	Days	If less than one day
65 65	7	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George
13. Birthplace Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MAR 2 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946 19 , at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1937 to Mar. 1 1946.
and that I last saw him alive on Mar. 1 1946.

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to Generalized Adeno-carcinosis - Prostate	
Due to	
Other Conditions	

(Include pregnancy, within 3 months of death)
Date of operation Biopsy typed back 4-25-45
Major findings of operation
of autopsy Chronic Adeno-carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Huntington Williams M.D.
Address 4940 Eastern Ave Date signed 3-2-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37998 BALTIMORE CITY HEALTH DEPARTMENT G37998

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Latrobe apts.
(c) Hospital or institution: Charles & Read Sts.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Latrobe apts. Charles & Read Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Meade Lee Rittler

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Henry F. Rittler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21 1879

8. AGE: Years 66 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace White Post Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Eustis Grymes Meade
13. Birthplace White Post Va.

MOTHER
14. Maiden Name Elizabeth F. Massey
15. Birthplace White Post Va.

16 (a) Informant Henry F Rittler
(b) Address Latrobe apts.

17 (a) Removal (b) Date thereof Mar 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meade Memorial
Location White Post Va.

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address McCulloh & Eutaw Sts.

19 (a) Huntington Williamsport, Md.
(Date received by registrar) (Signature of registrar)

MAR 3 - 1946

Rvd 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946 19 , at 11:30 M. A.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/1944 19 , to 3/2/1946 19 , and that I last saw h ex alive on 2/21/46 19 .

Immediate cause of death: Coronary heart disease — Duration: Sudden

Due to

Due to

Other Conditions: Rheumatoid arthritis of 6 yrs. duration.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thurm B Scott
Address 11 E. Chase St., Balto. Date signed 3/2/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G37999 ✓ G37999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Marine Hospital 84
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 months
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Pelham Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Norman L. Wilson

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 212-07-6155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife VERA MAE WILSON
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) MAY 3, ~~1900~~ 1898

8. AGE: Years	Months	Days	If less than one day
~~45~~ 47	9	24~~25~~	10 hr. 15 min.

9. Birthplace CAMBRIDGE MD.
(Town, county, and state)
10. Usual Occupation SUPERVISOR
11. Industry or business GAS & ELECTRIC

FATHER
12. Name WILLIAM WILSON
13. Birthplace CAMBRIDGE, MD.

MOTHER
14. Maiden Name MATTIE SMITH
15. Birthplace MD.

16 (a) Informant .....
(b) Address 2405 PELHAM AVE

17 (a) BURIAL (b) Date thereof 3 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location .....

18 (a) Funeral director A. R. SLADE
(b) Address 4907 YORK RD.

19 (a) 3 4 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1946, at 6 15 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Valvular Heart
Disease & Acute Cardiac Dilitation

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. J. Feldmeier M.D.
Medical Examiner.
Date signed 3/1/46

(over)

MARGIN RESERVED FOR... PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38000 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Doolittle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burwell Skinner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If ~~alive, give age~~ 28 - 1876

7. Birth date of deceased (mo., day, yr.) ~~Aug. 28 1876~~ ~~May 28 1875~~

8. AGE: Years	Months	Days	If less than one day
69 70	3	2 4	hr. min.

9. Birthplace Pitt Co., N. C.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name ? Skinner
13. Birthplace N. C.

MOTHER
14. Maiden Name ? Cox
15. Birthplace N. C.

16 (a) Informant Sidney Wilber
(b) Address 1602 Doolittle Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof MAR 6 1946 (month) (day) (year)
(c) Cemetery or crematory Remount
Location Greenville N. C.

18 (a) Funeral director A R Sladdle
(b) Address [illegible]

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946, at 1 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Arteriosclerotic cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fulton M.D.
Medical Examiner.
Date signed 3-3-46

(over)

G38001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38001 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give name)
(d) Street No. 2412 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice J. Welsh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 12 1864

8. AGE: Years 81 | Months 10 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Herman Welsh

FATHER 13. Birthplace Phila

MOTHER 14. Maiden Name Maria Cleary

MOTHER 15. Birthplace Phila

16 (a) Informant F. Clarence B. Welsh

(b) Address 2412 N. Calvert St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 4/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3301 Frederick Ave

18 (a) Funeral director John O'Donnell & Son

(b) Address 1900 Eutaw Place, Baltimore, Md.

MAR 3 - 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 March 1946, at 11:50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry, by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William G. Hetrick M.D. Medical Examiner.

Date signed 2 March '46

VS 151

G38002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G38002 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Windemere Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Windemere Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Margaret) Margie Taylor Chambers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Benjamin Chambers

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) August 19, 1907

8. AGE: Years 38 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Waycross, Ga.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Marion Johnson
13. Birthplace Greenlin County, Va.

MOTHER
14. Maiden Name Ida Lee Taylor
15. Birthplace Wilmington, N.C.

16 (a) Informant Benjamin Chambers
(b) Address 1506 Windemere Ave.

17 (a) Cremation (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Loudan Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 MAR 3 - 1946 (b) Huntington Wilkinson, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1- 1946, at 1:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions Self-inflicted

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1- at A. M.
(b) Where did injury occur? 1506 Windemere Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Unlighted gas range

23. Signature Howard J. Teasdale M.D.
Medical Examiner.
Date signed 3-1-46

VS 151

G38003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38003 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cambridge Arms Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cambridge Arms Apts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Harry E. Kelsey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Pauline Hamill
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) July 9, 1873

8. AGE: Years	Months	Days	If less than one day
72	9	20 23	hr. min.

9. Birthplace Kansas (Town, county, and state)
10. Usual Occupation dentist
11. Industry or business

FATHER
12. Name Samuel T. Kelsey
13. Birthplace N. Y. State

MOTHER
14. Maiden Name Katherine Richsecher
15. Birthplace ?

16 (a) Informant Mrs. Pauline H. Kelsey
(b) Address Cambridge Arms Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 3 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946 at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 1 1946 and that I last saw him alive on March 1 1946

Immediate cause of death CORONARY OCCLUSION (

Due to Accidents & wounds (Accidental Day-pt had coronary sclerosis

Due to Ulcer with Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Newland Edward Day M. D.
Address 4 E. 33rd St. Date signed 3-1-46

G38004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38004 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days. Gen. Service
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Old Annapolis Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Economy

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	216-09-8758

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	W	Married

6. (b) Name of husband or wife Laura Economy (Nee Moyna) 6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 11/7/88 ?

8. AGE: Years	Months	Days	If less than one day
57	3	14	hr. min.

9. Birthplace Greece - (Blasia) (Town, county, and state)
10. Usual Occupation Restaurant Mgr.
11. Industry or business W. Bro. Restaurant Glen Burnie

FATHER
12. Name Evangelist Economy
13. Birthplace Greece

MOTHER
14. Maiden Name Chrisoula Yanakoupoulos
15. Birthplace Greece

16 (a) Informant Jimmy Bevros
(b) Address Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Roman W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Date received (b) Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21, 1946, to March 1 1946, and that I last saw him alive on March 1 1946.

Immediate cause of death	Duration
Possible Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular disease	
Due to	
Other Conditions Pneumonia (Secondary)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Offermann M. D.
Address 2815 Ashland Ave Date signed 3-1-46

VS 150

G38005 BALTIMORE CITY HEALTH DEPARTMENT G38005

CERTIFICATE OF DEATH 1937 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lakewood & Greene
(c) Hospital or institution: University Hospital 14
1-19-46 2-27-46
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

8. AGE: Years	Months	Days	If less than one day
70	-	-	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name James Wilson
13. Birthplace Va

MOTHER
14. Maiden Name Emma
15. Birthplace Va

16 (a) Informant Myrtle Wilson
(b) Address 1413 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pennsylvania Ave

MAR 5 1946 (a) (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1946, at 12:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1946, to 2-27 1946, and that I last saw him alive on 2-27 1946.

Immediate cause of death	Duration
Cardiac failure	
Coronary occlusion	
Due to Hypertension Chronic Valvular disease C Grade 4	
Due to failure	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Dorcas Clark, M.D.
Address University Hospital 2-27-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38006 Registered No. 122B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 So Liglio SD

(c) Hospital or institution: So. Balto. Gen. Hosp. ont

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State D.C. (b) County —

(c) City or town Washington

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1232-4 th SD.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Forbes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Prince George, Co. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Forbes

13. Birthplace Md

MOTHER 14. Maiden Name Lizzie Simms

15. Birthplace md.

16 (a) Informant George Forbes

(b) Address 631 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)

(c) Cemetery or crematory Ont. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brentley ave

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md.

MAR 7 150 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1946, at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1946, to Feb 27 1946 and that I last saw him alive on Feb 27 1946.

Immediate cause of death	Duration
Acute Intestinal obstruction	
Due to Volvulus above an adhesion.	
Due to and secondary paralytic ileus.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation February 26, 46

Major findings of operation: Volvulus about an intestinal adhesion

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. M. W. [illegible] M.D.

Address 1213 S. Liglio Date signed 2/27/46

S.O.G.H.X

G38007 G38007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Argyle ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Argyle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha E. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank W. Hall
13. Birthplace Md

MOTHER 14. Maiden Name Mary V. Bell
15. Birthplace Md

16 (a) Informant James Bond
(b) Address 1314 argyle ave

17 (a) Burial (b) Date thereof 3/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brentleyn

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1946 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1945 to 3/1 1946
and that I last saw h[illegible] alive on 2/28 1946

Immediate cause of death	Duration
Hypertensive Type Heart Disease	
Due to Hypertension	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Evan O. Gibbs M. D.
Address 601 N. Calhoun Date signed 3/5/46

X

[illegible] for Vital Statistics

[illegible] 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

G38008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William N. Sears · William N. Sears

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 212-09-5761

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary L. Sears

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1888

8. AGE: Years 58 | Months — | Days 1 | If less than one day — hr. — min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Clerk - American

11. Industry or business Sugar Refinery.

FATHER 12. Name William T. Sears.

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Ida E. Rupp.

MOTHER 15. Birthplace Maryland

16 (a) Informant Mrs. Mary L. Sears.

(b) Address 2511 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn Road

18 (a) Funeral director A. B. Shubert & Son

(b) Address 1300 Eutaw Pl.

MAR 94 1946 (Date received) (Huntington Williams, registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1946, at 2 55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1946 to 3-1 1946 and that I last saw him alive on 3-1 1946

	Duration
Immediate cause of death: Acute Hemorrhagic Pancreatitis	6 days
Due to:	
Due to:	
Other Conditions: Lobar Pneumonia Rt. Base	7 days

(Include pregnancy within 3 months of death)

Date of operation 2-23-46

Major findings of operation: Acute Pancreatitis + P.O. Adhesions

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.

Address Bon Secours Date signed 3-1-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74A

Registered No. G38009

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) None.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Cecil~~ Cecil
(c) City or town Port Deposit
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Milton Waibel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1941

8. AGE: Years 4 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Port Deposit, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Russell William Waibel
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorothy Thompson
15. Birthplace Maryland

16 (a) Informant Mother.
(b) Address Port Deposit, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 6 1946 (month) (day) (year)
(c) Cemetery or crematory Westnottingham Cemetery
Location Colora, Md.

18 (a) Funeral director Ful A. Patterson & Son
(b) Address Perryville, Md.

19 MAR 4 - 1946 (Date rec'd by Registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Feb.~~ March 3 1946, at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1946 to ~~Feb.~~ March 3 1946 and that I last saw him alive on ~~Feb.~~ Mar. 3 1946.

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Anemia	
Due to Leukemia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Streeter M. D.
Address Date signed

VS 150

X

G38010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G38010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 N Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Hayden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1887 or 77

8. AGE: Years	Months	Days	If less than one day
69 ~~Years~~	1	28	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Doorman
11. Industry or business Kieths Theatre

FATHER
12. Name John R, Hayden
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane Byerly
15. Birthplace Pa.

16 (a) Informan: Bortz & Seeman Fun'l. Home
(b) Address Greensburg, Pa.

17 (a) Removal (b) Date thereof 3/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory --
Location Greensburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS, INC.
Address North & Penna. Aves.

19 (a) MAR 4 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 March 1946, at 11:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S Stetler M.D. Medical Examiner.
Date signed 3 March 46

G38011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. G38011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 St, Paul St,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Del (b) County Kent
City or town Smyrna Delaware
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ellen Waller Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem	White	Widowed

6 (b) Name of husband or wife Alonzo W. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1854

8. AGE: Years	Months	Days	If less than one day
92	-	20	hr. min.

9. Birthplace Salisbury Md
(Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name Manson Waller
13. Birthplace Md

MOTHER
14. Maiden Name Sallie N. Bradley
15. Birthplace Md.

16 (a) Informant V. Lay Phillips
(b) Address Smyrna, Delaware

17 (a) Burial (b) Date thereof March 7, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Odd Fellows
Location Smyrna, Delaware

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 MAR 4 - 1946 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946, 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1946, to March 3 1946, and that I last saw h[illegible] alive on March 3 1946.

Immediate cause of death	Duration
Cardiac decompensation	4 days
Due to Senile Arteriosclerosis	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas F. Phillips
Address 6 E Biddle St Date signed 3/5/46

VS 150

G38012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 C

Registered No. G38012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Labyrinth Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Labyrinth Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Grocery Store

FATHER
12. Name Abraham Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Reba ?
15. Birthplace Russia

16 (a) Informant Myles Katz
(b) Address 3308 Labyrinth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 4/46 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 W. North Ave.

19 (a) Filed by registrar MAR 1 - 1946 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946 at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1928 to Mch 3 1946.
and that I last saw him alive on Mch 2 1946

Immediate cause of death: Cerebral hemorrhage — Duration 2 days
Due to: Hypertension — 8 yrs
Due to:
Other Conditions: Cardiac hypertrophy fibrillation auricular — 2 mos
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos A Levinson
Address 12 Eager St Date signed Mch 3/46 M. D.

83 d

G38013

JL - 99185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G38013 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4940 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia Kurz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1883

8. AGE: Years	Months	Days	If less than one day
62	5	0	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Adolph Kurz
13. Birthplace Germany

MOTHER
14. Maiden Name Annie E. Schreiner
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director William Ott Inc
(b) Address 1217 St. Paul St

MAR 4 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by local reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1946 to Feb. 26 1946, and that I last saw h[illegible] alive on Feb. 28 1946

Immediate cause of death	Duration
Carcinoma of Breast with Generalized Carcinomatosis	4 yrs
Due to	
Due to	
Other Conditions Hypostatic Pneumonia (Include pregnancy within 3 months of death)	3 days

Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orell M.D.
Address Balto. City Hosp. Date signed 3-1-46

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38014

TH. 99587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G38014

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 South Lloyd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18th 1876

8. AGE: Years 69 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Young (D
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Payne (D
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Dm Cathedral
Location Baltimore Md

18 (a) Funeral director Tallman Lodge Inc
Address 1217 St Paul St

19 (a) MAR 4 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23rd 1946 19 , at 9.58 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19th 19 46 to Feb. 23 19 46 and that I last saw him alive on Feb. 23 19 46

Immediate cause of death Malnutrition — Duration unknown
Carcinoma of Face — Duration unknown
Due to general Arteriosclerosis — Duration unknown
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell Nellenville M. D.
Address Baltimore City Hosp Date signed 3-2-46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G38015 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 N Patterson Pk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Usual Residence~~ (If rural give location)
1903 N Patterson Pk Ave
(e) If foreign born, how long in U. S. A.? 75 yrs years

3 (a) FULL NAME Conrad Lind

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Dora Lind
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1870

8. AGE: Years 75 | Months 4 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired Broom Manf
11. Industry or business

FATHER
12. Name Andrew Lind
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Lind
15. Birthplace Germany

16 (a) Informant Mrs Dora Lind
(b) Address 1903 N Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-1946 (month) (day) (year)
(c) Cemetery or crematory Balto Cemetery
Location Hamilton Ave & Rose St

18 (a) Funeral director Albert L Hilt Jr
(b) Address 1606 N Chester St

19 (a) MAR 4 1946 (Date received by Registrar) Hamilton Ave & Rose St

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946, at 7.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to March 1 1946 and that I last saw him alive on March 1 1946

Immediate cause of death: Cardiac Dilatation and Senility — Duration 1 Yr 2 Mo 4/5

Due to: Cyanosis of — 9 Hr 24 Mo

Due to: Right Lung — 9 Hr 24 Mo

Other Conditions →

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert L Hilt Jr
Address 1605 E Madison Date signed 3/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-C

G38016 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Whitelock St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Whitelock St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD M. NEWMAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife Fannie M. Newman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1885.

8. AGE: Years 60 | Months 6 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Clothing Mnfgr.
11. Industry or business

FATHER
12. Name Max Newman,
13. Birthplace Vienna.

MOTHER
14. Maiden Name Rose Sulke,
15. Birthplace London, Eng.

16 (a) Informant Mrs. Fannie M. Newman,
(b) Address 611 Whitelock St.

17 (a) Burial (b) Date thereof 3. 4. 46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Sherbert Sonneborn's Son
(b) Address 1902 Eutaw Place.

19 (a) ... (b) ...
Date filed by registrar ... Registrar

MAR 4 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd. 1946. at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1946 to 3/2 1946 and that I last saw h[illegible] alive on 3/2 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 2 Hours

Due to: Hypertension — 20 years

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Theodore Cooper M. D.
Address 2201 Eutaw Place. Date signed 3/3/46

G38017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38017 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 Clifton ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Clifton ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Counts

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-6353

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1888

8. AGE: Years 57 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Columbia, S.C.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Thomas Counts
13. Birthplace Newberry, S.C.

MOTHER
14. Maiden Name Fannie Luber
15. Birthplace Newbury, S.C.

16 (a) Informant Miss Frathrina Counts
(b) Address 2415 Federal St. S. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Eden Cemetery
Location Philadelphia, Pa.

18 (a) Funeral director Thos. Gudge A. Holland
(b) Address 1631 Druid Hill Ave.

MAR 4 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946 at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frates M.D.
Medical Examiner.
Date signed 3-3-46

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D ✓

G38018
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 S. Highland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry McNew

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-8330

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret Fraas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1881

8. AGE: Years	Months	Days	If less than one day
64	4	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Helper Mch. Shop
11. Industry or business Baugh Chemical Co.

FATHER
12. Name Frank
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Freidewaldt
15. Birthplace Baltimore

16 (a) Informant Wife
(b) Address 917 S. Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAR 4 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1946, at 4 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1945 to 2-28 1946, and that I last saw h~~e~~ alive on 2-27-1946

Immediate cause of death	Duration
Chr Bronchial asthma	5-15-45
Due to Chr. Emphysema	5-15-45
Acute Infectious arthritis	2-14-46
Due to Acute coronary occlusion	2-27-46
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. A. Schumacher M. D.
Address 942 S. Ext Ave. Date signed 3-1-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38019
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 NOTRE DAME LANE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ALL LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 NOTRE DAME LANE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANOR ALLERS

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-4658

4. Sex FEM.

5. Color or race W

6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/20/1928

8. AGE: Years 17 | Months 4 | Days 9 | If less than one day 12 hr. min.

9. Birthplace BALTIMORE, Md
(Town, county, and state)

10. Usual Occupation STUDENT

11. Industry or business STUDENT

FATHER
12. Name HERMAN L. ALLERS
13. Birthplace McDONOUGH, BALTIMORE Co

MOTHER
14. Maiden Name MATILDA C. CROUSE
15. Birthplace GWYNN BROOK, BALT. Co

16 (a) Informant MOTHER MRS. M.C. ALLERS
(b) Address 403 NOTRE DAME LANE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 4/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick, Rd

18 (a) Funeral director Harry H. Little
(b) Address 401 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 4 - 1946

Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 1 1946 at 9 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 15 1945 to MARCH 1 1946 and that I last saw HER alive on MARCH 1 1946

Immediate cause of death PULMONARY TUBERCULOSIS — Duration 5yrs 6mos

Due to

Due to

Other Conditions TB ENTERITIS — 6MOS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Aller M. D.

Address 6919 HARFORD ROAD Date signed 3/1/46

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38020 ✓ FINECEY ✓ 159 G38020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 548 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Laure Finecey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James R. Finecey
13. Birthplace Md.

MOTHER
14. Maiden Name Pauline Finecey
15. Birthplace Md.

16 (a) Informant Pauline Finecey
(b) Address 548 N. Payson St.

17 (a) Burial (b) Date thereof Mar. 4 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Cem.
Location Baltimore

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) Date rec'd MAR 4 1946 (b) Thurston Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/46 19 at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1946 to 3/2 1946 and that I last saw h[illegible] alive on 3/2/46 19

Immediate cause of death	Duration
Respiratory failure	
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Bailey M. D.
Address Mercy Date signed 3/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 70

G38021
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Race Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/3/45

8. AGE: Years | Months: 8 | Days: 28 | If less than one day: hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Lewis
13. Birthplace md

MOTHER 14. Maiden Name Dorothy Arnold
15. Birthplace md

16 (a) Informant Dorothy Lewis
(b) Address 1017 Race St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a.a. co md

18 (a) Funeral director Isaiah T Brown & Son
(b) Address 106 W Montgomery St

19 (a) Date rec'd by Registrar MAR 4 - 1946 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946 at 11 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rickets

Due to

Other Conditions Enlargement of the thymus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Eastman M.D.
Medical Examiner.
Date signed March 1st 1946.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G380,22 — BALTIMORE CITY HEALTH DEPARTMENT — G380,22

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hospital (E.R.)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore #1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 W. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emanuel King | 6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 2-15-07

8. AGE: Years 39 | Months - | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Norfolk, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Norman Holley

13. Birthplace Va

MOTHER 14. Maiden Name Clara Owens

15. Birthplace Va

16 (a) Informant Mary Holley

(b) Address 207 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Arbutus Md.

18 (a) Funeral director Charles R. Law

(b) Address 802 Mad. Ave.

19 (a) MAR 4 - 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2 1946, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 3-2 1946, and that I last saw her alive on 3-2 1946.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertensive Cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Franklin Holley M. D.

Address 1543 Eden Ave Date signed 3/7/46

VS 150

Huntington Williams, M.D.

X

G38023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G38023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT FOLD OR USE PINS OR CLIPS FOR BINDING

COPYRIGHT RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 E. 41st St.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 E. 41st St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Regan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Richard F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18-1870

8. AGE: Years 75 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Frank J. Hockel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary L. Bolling
15. Birthplace Balto. Md.

16 (a) Informant Richard F. Regan
(b) Address 618 E. 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/46 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road.

18 (a) Funeral director John A. McKew
(b) Address 601 Greenmount Ave

19 (a) Received by registrar MAR 4 - 1946 (b) Registrar Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION 4:30

20. DATE OF DEATH March 2 1946, at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1945 to Mar. 2 1946 and that I last saw her alive on March 2 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 30 hrs.

Due to: Hypertension — Duration 5 yrs.

Due to: Coronic nephritis, Artiris sclerosis — Duration 5 years

Other Conditions: Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barnes & Baggott

Address 3812 Greenmount Ave Date signed 3/2/46

Baltimore Md

G38024 Gibmeyer ✓ G38024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 N. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N Linwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Gibmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-9997

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Eva Gibmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1885

8. AGE: Years	Months	Days	If less than one day
60	7	8	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Shipping

FATHER
12. Name John F. Gibmeyer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Agnus Schuette
15. Birthplace Italy

16 (a) Informant Eva Gibmeyer
(b) Address 503 N Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John G Moran
(b) Address 3000 E Baltimore St

19 MAR 4 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to 3/1 1946 and that I last saw h[illegible] alive on 2/1 1946.

Immediate cause of death	Duration
a. Acute myocardial insufficiency	10 min.
Due to: b. Coronary occlusion	3 yrs.
Due to: c.	
Other Conditions: arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Botticelli
Address 447 N. Kenwood Ave Date signed 3/3/46

VS 150

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38025 ✓ G38025

BALTIMORE CITY HEALTH DEPARTMENT

G38025 CERTIFICATE OF DEATH 830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 E. 25th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matilda F. Gill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Dr. Richard L. Gill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1878

8. AGE: Years 68 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Louis Fehsenfeld
13. Birthplace Germany

MOTHER
14. Maiden Name Helena Peters
15. Birthplace Germany

16 (a) Informant Mrs. Katharine L. Forster
(b) Address 3045 Guildford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert street.

19 (a) (Date rec'd by registrar) MAR 4 1946 (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946, at 10. 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1946 to Mar 3 1946, and that I last saw h alive on 19

	Duration
Immediate cause of death Cerebral Hemorrhage	2wks
Antecedent causes Arteriosclerosis	5 yrs.
Due to Internal Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. D. Lyon M. D.
Address 1525 Eutaw Place Date signed 3/4/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58 D G38026

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Brunt (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Cure

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1940

8. AGE: Years 5 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name George Cure
13. Birthplace Md

MOTHER
14. Maiden Name Mary Harcum
15. Birthplace Md

16 (a) Informant Mary Cure
(b) Address 2006 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Freestman St

19 (a) (Date rec'd by Registrar) MAR 4 1946 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1946 at 5 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1946 to 3-1 1946 and that I last saw h/m alive on 3-1 1946

Immediate cause of death Lung Mycardial failure — Duration 2 weeks

Due to Rheumatic Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Redden M.D.
Address 420 N. Gilmor Date signed 3-4-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638027 ✓ 638027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N. Bauedin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Willhide

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1890

8. AGE: Years: 55 | Months: 4 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Freight, Penna R.R.

11. Industry or business

FATHER — 12. Name: Martin Willhide

13. Birthplace: Balto.

MOTHER — 14. Maiden Name: Julia Tolsom

15. Birthplace: Balto.

16 (a) Informant: Katherine Willhide

(b) Address: 429 N. Baudin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 6/46 (month) (day) (year)

(c) Cemetery or crematory: National Cem.

Location: Balto. Md

18 (a) Funeral director: Wm. J. Frund & Son

(b) Address: 2007 Orleans

19 (a) (Date rec'd by ...) (b) Huntington Williamsport, Md.

MAR 4 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3- 1946 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3/3/46 at 3-2 ? M.

(b) Where did injury occur? Harbor, Lancaster & Central Aves.

(c) Did injury occur at home, on farm, industrial place, in public place? Probable While at work? ---

(d) Means of injury Drowning

23. Signature: Robert Lee Graham M.D. (Medical Examiner.)

Date signed 3-3-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38028 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Hudson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Shealy Cofer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John W. Cofer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1887

8. AGE: Years	Months	Days	If less than one day
58	10	8	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Patrick Downey
13. Birthplace Balto

MOTHER
14. Maiden Name Catherine F. Lynch
15. Birthplace Baltimore

16 (a) Informant John W Cofer
(b) Address 3116 Hudson St

17 (a) Burial (b) Date thereof March 5
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Dorsey

18 (a) Funeral director Weigel Funeral Home
(b) Address 2008 Orleans St

19 (a) (b)
(Date received by reg.) (Registrar's signature)

MAR 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946, at 10:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Mar 1 1946, and that I last saw h alive on March 1 1946

Immediate cause of death	Duration
Diabetes Mellitus	1-2-44
Generalized Arteriosclerosis	1-2-44
Due to (b) Cystic Encephalomalacia	1-15-46
(c) Encephalitis	1-15-46
Due to (d) Impacted Feces	2-27-46
Other Conditions Tumor	

(Include pregnancy within 3 months of death)
Date of operation Final
Major findings of operation:
of autopsy: Final

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Date signed 3-2-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G380,29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G380,29 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymond Sts.
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Glendale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Anthony Morley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1946

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Morley
13. Birthplace Worcester, Mass.

MOTHER 14. Maiden Name Miriam Jones
15. Birthplace Xenia Ohio

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof 3-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loveland Memorial
Location Baltimore

18 (a) Funeral director George Farley
(b) Address Fulton & Fayette Sts.

19 (a) MAR 4 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 | 3 | 1946. 11:32 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946 to 3-3 1946 and that I last saw him alive on 3-3 1946.

Immediate cause of death Osteolastoma | Duration

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature A. Silverfeld M. D.
Address West Balto. Gen. Hosp. Date signed 3/5/46

VS 150

G38030 G38030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. North Point Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LUKYAN POLUKOWITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Farmer.

11. Industry or business

FATHER
12. Name Timothy
13. Birthplace Poland

MOTHER
14. Maiden Name Maria ?
15. Birthplace Poland

16 (a) Informant Alex Moravsky
(b) Address North Point Road, Md.

17 (a) Burial (b) Date thereof 3 4 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto Co. Md

18 (a) Funeral director James J. Brundage
(b) Address 607 Eastern Ave. Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 MAR 4 - 1946 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 46, at 7 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 19 46, to 3-1 19 46, and that I last saw h~~im~~ alive on 3-1 19 46

Immediate cause of death	Duration
Acute Pulmonary Edema	1 day
Due to Congestive Failure	1 day
Due to Chronic Glomerulonephritis	years
Other Conditions Hypoproteinaemia	? ?

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Ebeling, III M. D.
Address University Hospital Date signed 3-1-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38031 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Julius E. Haroth

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-12-4402

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1872

8. AGE: Years 73 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Sheet Metal Worker

FATHER 12. Name Carl H. L. Haroth

13. Birthplace Germany

MOTHER 14. Maiden Name Anna F. Drebel

15. Birthplace Germany

16 (a) Informant Mrs. Maria Haroth

(b) Address 1706 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 4/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location 3801 Frederick Ave

18 (a) Funeral director Harry H. Whitelo

(b) Address 4101 Edmondson Ave

MAR 4 - 1946 (a) (Date received by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1946 to Feb 28 1946, and that I last saw h[illegible] alive on Feb 28 1946.

Immediate cause of death	Duration
Hypostatic C. V. D.	
Due to	
Due to	
Other Conditions Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel J. Hankins M. D.

Address 2031 Eaton Pk Date signed 3/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SCHROEDER X ✓

G38032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38032 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] St Agnes Hosp
(c) Hospital or institution:
Wilkens Ave + Caton Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6318 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Anna Schroeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1883

8. AGE: Years 62 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation H

11. Industry or business

FATHER
12. Name Wm a. Barnes
13. Birthplace Md

MOTHER
14. Maiden Name Anna A Waybee
15. Birthplace Md

16 (a) Informant John F. Schroeder
(b) Address 6318 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5 1946 (month) (day) (year)

(c) Cemetery or crematory National
Location 5300 Frederick Ave

18 (a) Funeral director Harry N Weybe
(b) Address 4101 Edmondson Ave

19 (a) MAR 4 - 1946 (b) Registrar
Date rec'd by registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 2 1946 at 10 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to Mar 2 1946, and that I last saw h[illegible] alive on Mar 2 1946

Immediate cause of death: Cardio Respiratory failure — Duration

Due to: Hypertensive Cardio Vasc Disease

Due to:

Other Conditions Uraemia Nephritis E Coma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Leavitt D.

Address St Agnes Hosp Date signed 3/5/46

937

G38033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38033
Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 71

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5911 Arabia Ave (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Kohoutek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph F Kohoutek | (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/13/73

8. AGE: Years 72 | Months 10 9 | Days 17 20 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Vaclav Libich
13. Birthplace Czechia

MOTHER 14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Joseph F Kohoutek
(b) Address 5911 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto 6, Md.

18 (a) Funeral director Frank Brack & Son
(b) Address 900 N. Chester St 5

MAR 4 - 1946 (Date received by Registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 19 46 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27/46 19 46 to 3/2 19 46, and that I last saw her alive on 3/2 19 46

Immediate cause of death Cardio-respiratory failure

Due to Auricular fibrillation

Due to Arteriosclerotic cardio vascular disease.

Other Conditions Marked edema & ulceration of legs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J Ayd Jr. M.D.
Address St Josephs Hosp Date signed 3/4/46

G38034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G38034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING must not be written over. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 N. Duncan St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 631 N. Duncan St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Siart

3 (b) If veteran, name war: Mexican, Spanish-American, World War I
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Siart
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1881

8. AGE: Years 65 | Months 1 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Massachusetts (Town, county, and state)

10. Usual Occupation Soldier-Retired

11. Industry or business

FATHER
12. Name Jacob Siart
13. Birthplace Germany

MOTHER
14. Maiden Name Not known
15. Birthplace " "

16 (a) Informant Catherine Siart
(b) Address 631 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-46 (month) (day) (year)
(c) Cemetery or crematory U. S. NATIONAL
Location Maryland

18 (a) Funeral director Frank Brach & Son
(b) Address 600 W. Chester St.

MAR 4 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946, at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 3 1946, and that I last saw h[illegible] alive on March 3 1946.

Immediate cause of death: Coronary Thrombosis — Duration 3 days.
Due to: Arteriosclerotic Cardiovascular Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel B Wolfe
Address 1331 Eutaw Place Date signed 3-7-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

Registered No. G38035

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 252 Spring Court
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Geraldine Theresa Thillman Thilmany

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16 1933

8. AGE: Years 12 | Months 7 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER
12. Name John N. Thilmany
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lola C. Grover
15. Birthplace Calvert County Md.

16 (a) Informant Lola C. Cavaliare (Mather)
(b) Address 252 Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5/46 (month) (day) (year)

(c) Cemetery ~~xxxxxx~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 Morley St.

19 (Date rec'd by registrar MAR 4 - 1946) Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946 at 4 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1-46 at 3 15 P. M.
(b) Where did injury occur? Eden & Gough Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 3-2-46.

G380.36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G380.36

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325.W.Lafayette. Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50. yrs.

2. USUAL RESIDENCE OF DECEASED:
Md.
(a) State (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325W.Lafayette. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUCY THOMPSON STANSBURY.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4 Sex	5 Color or race	6 (a) Single, married, widowed, or divorced
Female.	Col.	?

6 (b) Name of husband or wife
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Mar. 2. 1875.

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Normany W-Virginia.
(Town, county, and state)
10. Usual Occupation Domestic.
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Siney Rolls.
15. Birthplace Va.

16 (a) Informant Esther Mc Millen.
(b) Address 1902. Etting.St.

17 (a) Burial (b) Date thereof 3. 6.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetry.
Location Baltimore.Md.

18 (a) Funeral director Wm.A. Jackson.
(b) Address 916.Penna. Ave.

19 (a) MAR 4 - 1946 (Date rec'd by registrar) Registrar for Milwaukee

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1946 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1945 to 3-2-1946 and that I last saw her alive on 2-28-1945.

Immediate cause of death	Duration
Chronic myocarditis	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell, M. D.
Address 718 Dolphin St. Date signed 3-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G38037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 Jackson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Jackson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Riggin Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4-1897

8. AGE: Years 48 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Policeman

FATHER
12. Name Albert J. Riggin Sr.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Josephine D.
15. Birthplace Baltimore Md.

16 (a) Informant Theresa Rachel Riggin
(b) Address 1602 Jackson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md.

18 (a) Funeral director Flynn & Feeney
(b) Address 1426 Light St.

19 (Date rec'd by registrar) MAR 4 - 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1946 to March 2 1946, and that I last saw him alive on March 1 1946.

Immediate cause of death Advanced Pulmonary Tuberculosis — Duration 3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy: and

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James E. Peterman

Address 126 Hanover St. Date signed 3/4/46

VS 150

G38038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38038

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 S. Port St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 S Port
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Rohda

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles Rohda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1869?

8. AGE: Years ? 77 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Burkhard Schmitt

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Mary

15. Birthplace Germany

16 (a) Informant Anthony J. Mullen

(b) Address 432 E Lorraine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Baltimore Md.

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights Ave

19 (a) MAR 4 - 1946 (Date rec'd by Registrar) (b) Huntingtown, Md.

MEDICAL CERTIFICATION 4:00

20. DATE OF DEATH March 1 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1943, to March 1 1946 and that I last saw her alive on March 1 1946.

Immediate cause of death

Myocarditis Chronic — Duration 2 years.

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Lemmon Jr MD

Address 2431 Fait Ave Date signed 3/11/46

M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G38039 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 W Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1875

8. AGE: Years 71 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER
12. Name Alex Jones
13. Birthplace Va

MOTHER
14. Maiden Name Annie Barnett
15. Birthplace Va

16 (a) Informant Annie Hicks
(b) Address 1623 W Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Social D Brown Son
(b) Address 1615 Montgomery St

19 (a) MAR 4 1946 (Date received) (b) Registrar

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 1945 to 3/1 1946.
and that I last saw h— alive on 3/1 1946.

Immediate cause of death	Duration
Pneumonia	2 wks
Due to Interpalentin Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 426 N. Gilmor St Date signed 3/2/46

G38040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38040 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec'd
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen D. Hutte

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Carl W. Hutte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1903

8. AGE: Years	Months	Days	If less than one day
42	4	17	hr. min.

9. Birthplace Mass.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Dwyer
13. Birthplace Mass.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16. (a) Informant Carl W. Hutte
(b) Address 1523 Eutaw Place

17 (a) Buried (b) Date thereof 3/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Gahagan Sons
(b) Address 1827 N. North Ave.

19 (a) Filed MAR 4 1946 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946, at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Acute cardiac dilatation, chronic myocarditis,

Due to

Other Conditions pulmonary edema and congestion, marked
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed 3-2-46

G38041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G38041

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2042 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2042 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Osterman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1868

8. AGE: Years 77 | Months 11 | Days 18 | If less than one day hr. min. 22

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Stone
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant George Osterman
(b) Address 2042 N. Fulton Ave.

17 (a) Burial (b) Date thereof 3/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2 1946, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1946, to Mar. 2 1946, and that I last saw h-er alive on Mar. 1 1946

Immediate cause of death

Due to Chr. Myocarditis — Duration 1940

Due to Chr. Interstitial Nephritis — Duration 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Braun M. D.

Address 1663 W. North Ave Date signed 3/3/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G38042
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 Hubert St
(c) Hospital or institution: Herbert. 1 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Hubert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evan R. Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Carey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.
69

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Earl R. Carey
(b) Address 2109 Hubert St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Martin Tobey & Sons
(b) Address 1827 N. North Ave.

19 (a) MAR 4 - 1946 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to March 4 1946 and that I last saw h[illegible] alive on March 2 1946.

Immediate cause of death Acute Bronchopneumonia — Duration 4 days

Due to Chronic Bronchiectasis — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Gerlman M.D.

Address 1910 Eutaw Pl. Date signed 3/4/46

VS 150

G38043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G38043
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 Myrtle ave
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State V (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Myrtle ave (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Grobb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

(b) Name of ~~husband~~ or wife Charles Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1886

8. AGE	Years	Months	Days	If less than one day
	59	2		hr. min.

9. Birthplace Calvert Co. md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Frederick Freeland
13. Birthplace Calvert Co, md

MOTHER
14. Maiden Name Priscilla ?
15. Birthplace Calvert Co. md

16 (a) Informant Dorothy Gross
(b) Address 1416 Myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof mch 4 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location A.A. Co. Md

18 (a) Funeral director Robert Williams
(b) Address 515 W. Lafayette

MAR 4 1946

19 (a) (b) (Date rec'd by registrar) Huntington Williams Reg.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946, at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1946, to Feb 28 1946, and that I last saw her alive on Feb 27 1946.

Immediate cause of death

Due to Apoplexy

Due to Hypertension Cardiac Odema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature John Woodridge

Address 703 W Lafayette Date signed 2-28-46 M. D.

X

G38044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G38044 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 N. Homewood Avenue
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 6
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 N. Homewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Stewart Deal Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish-American	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 28, 1876

8. AGE: Years	Months	Days	If less than one day
69	10	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Receiving Clerk
11. Industry or business John Duer & Sons

FATHER
12. Name John T. Deal
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rebecca J.
15. Birthplace Maryland

16 (a) Informant Beverly M. Harrison
(b) Address 2225 N. Homewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 4 1946 (Date rec'd by registrar) (b) Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1946 to Mar 2 1946 and that I last saw h[illegible] alive on Mar 1 1946.

Immediate cause of death	Duration
Carcinomatosis	
Due to Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1945
Major findings of operation: Carcinoma of Rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob J. Singer M. D.
Address 506 E. North Ave Date signed 3-4-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946

Registration No. G38045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 344 Rossiter Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 344 Rossiter Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J Ernest Keyworth

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1882

8. AGE: Years	Months	Days	If less than one day
63	11	2	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business City Highway Dept

FATHER
12. Name Charles E Keyworth
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susan Milburn
15. Birthplace Baltimore, Md.

16 (a) Informant Elizabeth Keyworth
(b) Address 344 Rossiter Ave

17 (a) Burial (b) Date thereof March 6, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St., Baltimore, Md

19 (a) MAR 4 - 1946 (b)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 JAN 1946 to 3 MAR 1946 and that I last saw him alive on 2 MAR 1946.

Immediate cause of death	Duration
Coronary Thrombosis	Twelve
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave. Date signed Mar 6 '46

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38046 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 W University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Annie Crowther

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Frank Crowther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 7 1867

8. AGE: Years 78 yrs. Months 5 Days 26 If less than one day hr. min.

9. Birthplace Ellicott City Md (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Henry Henke
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Kopp
15. Birthplace Md

16 (a) Informant Mrs Jno B. Nicols
(b) Address 806 W University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wilson & Son
(b) Address 1314 E Baltimore St

19 MAR 4 1946 (Date rec'd by local reg.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/1946 at 11 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2/1946, to 3/3/1946 and that I last saw her alive on 3/3/1946

	Duration
Immediate cause of death: Uremia	
a Congestive Heart Failure	72 hrs.
Due to: Arteria Sclerotic C.V. Disease	
Due to: Diabetis Mellitus	
Other Conditions: Bronchial Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Martin Jr.

Address 15 E Lexington Bltg. Date signed 3/5/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38047 — Registered No. G38047

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Glenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Glenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie R Hinson

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1884

8. AGE: Years	Months	Days	If less than one day
61	9	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Tanneitz
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Thomas Hinson
(b) Address 710 Glenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1346 W Cold

19 (a) MAR 4 1946 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946, at 10 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Mar 3 1946 and that I last saw her alive on Mar. 3 1946

Immediate cause of death	Duration
CORONARY ARTERY DISEASE	2 mos.
Due to Hypertensive Cardio-Vascular Disease	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas Hinson
Address 5217 York Rd Date signed 3.4.46

Huntington Williamsport, Md

G38048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 G38048

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5618 Greenhill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George H Weickert (or) Wiechert

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife: Mae S.
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 23, 1894

8. AGE: Years	Months	Days	If less than one day
51	7	9	....hr. ....min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation policeman
11. Industry or business Balto. City

FATHER
12. Name Christopher Wiechert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lucy Pedvin
15. Birthplace Baltimore, Md.

16 (a) Informant Mae S. Wiechert
(b) Address 5618 Greenhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/46 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address 400 N. Gay & Ann Sts.

19 (a) MAR 4 1946 (Date rec'd by registrar) (b) Huntington Woods, Md. Residence

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1946, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sullivan M.D. Medical Examiner.
Date signed 3/1/46

G38049

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38049

CERTIFICATE OF DEATH /340 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Poplar Grove Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie M. Smith

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Howard Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1870

8. AGE: Years	Months	Days	If less than one day
75	7	9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Tucker
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret Stultz
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Henry W. Scott
(b) Address 3603 Clifton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

MAR 4 - 1946 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8, 1938 to Mar. 3 1946, and that I last saw her alive on March 2, 1946.

Immediate cause of death Pyonephritis — Duration
Due to Bilateral nephrolithiasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret Kupp M.D.
Address 3030 Edmondson Ave. Date signed 3/4/46

X

G38050 ✓ G38050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4408 Maine Ave.
(c) Hospital or institution: 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WASHINGTON ROBY PURNELL, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Nora Purnell
6 (c) If alive, give age ~~86~~ years

7. Birth date of deceased (mo., day, yr.) July 15, ~~1860~~

8. AGE: Years	Months	Days	If less than one day
~~81~~ 85	7	18	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Art Dealer
11. Industry or business

FATHER
12. Name Charles Irving Purnell
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Marcelline Roby
15. Birthplace Md.

16 (a) Informant Mr. W. Roby Purnell, Jr.
(b) Address 4408 Maine Ave.

17 (a) Burial (b) Date thereof 3/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 4 - 1946 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946 at 6.15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1945 to March 2 1946 and that I last saw him alive on March 2 1946;

Immediate cause of death	Duration
(a) - Coronary Thrombosis	Immediate
Due to - Arterio - Sclerotic Heart Disease	(15 months) 5 yrs.?
Due to	
Other Conditions Duodenal Ulcer	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation - Jan - 1946
Major findings of operation: - Ulcer & sclerosis of duodenum
Autopsy? - None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Thurston M. D.
Address 4108 Liberty Hts Date signed 3/4/46

VS 150 (OVER) X

G38051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G38051

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fonseca

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26, 1946

8. AGE: Years	Months	Days	If less than one day
			hr. 20 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Reynolds
13. Birthplace North Carolina

MOTHER
14. Maiden Name Audrey Fonseca
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 4 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH February 26 1946, at 12:53 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1946 to Feb. 26 1946, and that I last saw him alive on Feb. 26 1946

Immediate cause of death	Duration
? intrapartum infection	
? sodium pentothal narcosis	
Cause. ? intracranial hemorrhage	
? syphilis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Gilbert J. Vostrough M. D.
Address Johns Hopkins Hospital Date signed 2-26-46

VS 150

5333

X

G38052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G38052
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 E. Jefferson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 23, 1946

8. AGE: Years	Months	Days	If less than one day
			hr. 45 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Jones
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Beulah Barnes
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 2 1946
18 (a) Funeral director Commissioner of Health
(b) Address

MAR 4 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1946, at 7:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1946 to Feb. 23 1946, and that I last saw h im alive on Feb. 23 1946.

Immediate cause of death	Duration
Fractured skull, subarachnoid hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gilbert J. Vosburgh M.D.
Address Johns Hopkins Hospital Date signed 2-25-46

VS 150

3332

G38053 G38053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 W. Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Christina E. Hudson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1879.

8. AGE: Years 67 | Months | Days 21 | If less than one day hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation Lumber Millworker

11. Industry or business Retired, 10 yrs.

FATHER
12. Name Thomas W. Hudson
13. Birthplace Delaware

MOTHER
14. Maiden Name Glen Morris
15. Birthplace Delaware

16 (a) Informant Mrs. Christina Hudson
(b) Address 2702 W. Fairmount Ave.

17 (a) Burial (b) Date thereof March 5/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Harry F. Leitzke
(b) Address 4101 Edmondson Ave.

MAR 4 1946 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2 1946, at 6 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1946 to Mar 2 1946, and that I last saw h alive on Mar 2 1946

Immediate cause of death: Myocardial degen — Duration 4 yrs
Due to: Arteriosclerosis — 10 yrs
Due to: Diabetes Mellitus — 15 yrs
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. L. Dodd M. D.
Address 2108 St Paul St Date signed 3/4/46

G38054 G38054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1253 Registered No.

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County
(c) City or town Ferndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 660 W. Lewiston Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Herney, Edward Peter

3 (b) If veteran, name war

3 (c) Social Security Account No. 376-07-0547

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Daisy W. Herney
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 29, 1885

8. AGE: Years	Months	Days	If less than one day
60	8	4	hr. min.

9. Birthplace: Lebanon, Pa. (Town, county, and state)
10. Usual Occupation: Chief engineer
11. Industry or business: Seafarer

FATHER
12. Name: Steven Herney
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden Name: Anna Michael
15. Birthplace: Czechoslovakia

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory: FERNDALE, MICHIGAN
Location

18 (a) Funeral director: WM.J.TICKNER & SONS
(b) Address: NORTH & PENNA. AVES, I7 BALTIMORE, MD

19 MAR 4 - 1946 (Date rec'd by reg.) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3 1946, at 10:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1946, to Mar. 3 1946, and that I last saw him alive on Mar. 3 1946

Immediate cause of death: Acute hepatitis — Duration: 3 wks.

Due to:

Due to:

Other Conditions: Toxic nephritis with fatal uremia — Duration: 3 wks.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Clifford F. Moran M. D.
Address: PA Surgeon, US PHS Date signed 3/4/46
US Marine Hospital, Balto, Md.

G38055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

G38055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 Patapsco Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Patapsco Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Emma A. Farring

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Robert M.
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 9th 1869

8. AGE: Years	Months	Days	If less than one day
76	11	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name John Budesheim
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Bidel
15. Birthplace Maryland

16 (a) Informant Mrs Edith Anderson
(b) Address 519 Maude Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John J Kenny Inc
(b) Address 716 Light St

19 (a) (b) Huntington Williams, M.D. Registrar

Date rec'd by reg. MAR 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1946, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Mar 4 1946, and that I last saw her alive on Mar 3 1946

Immediate cause of death	Duration
cerebral hemorrhage	
hypertension	
Due to	
Due to	
Other Conditions hypertrophic arthritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. W. Keister
Address 302 Patapsco Ave Date signed 3/7/46

X Keister

G38056
CWS-99436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. G38056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50- 3- 18-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 Macon Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Frederick Medinger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14-1895

8. AGE: Years	Months	Days	If less than one day
50	3	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Medinger (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Julia Rohlfing
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Frederick Road
18 (a) Funeral director John J. Connelly
(b) Address Est. 21, Md.
19 (a)
(Date received by Registrar) Registrar

MAR 5 1946

VS

MEDICAL CERTIFICATION

A

20. DATE OF DEATH March 2 1946, at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1946, to Mar. 2 1946, and that I last saw h. alive on Mar. 2 1946

Immediate cause of death (a) Bronchopneumonia
Contributory
Due to (b) Chronic Myocarditis
Due to (c) Arterial Sclerosis

Duration
3

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert Kopf M.D.
Address Date signed 3-7-46

Huntington Williams, M.D.

G38057 G38057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM LEVIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1, 1883

8. AGE: Years	Months	Days	If less than one day
62	4	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Louis Levin
13. Birthplace Poland

MOTHER
14. Maiden Name Lanzer
15. Birthplace Poland

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-46 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St
19 (a) (Signature of local registrar) (b) Filing MAR 5 1946 Huntington Hillsboro, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946 at 745 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1946, to 3-2 1946, and that I last saw him alive on 3-2 1946

Immediate cause of death Cachexia — Duration

Due to Lymphomatous Degeneration

Due to

Other Conditions Myocardial fibrosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Probable lymphosarcoma (gland)

of autopsy: Lymphomatous Neoplasm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley R Steinbach M. D.
Address Sinai Hospital Date signed 3-4-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38058 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Liberty Hgts Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Zeller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Etta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Jean Arkin
(b) Address 2739 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-46 (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location

18 (a) Funeral director Ace Lewis Inc
(b) Address 1439 E Balto St

19 (a) (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4-1946, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26-1946 to 3-4-1946 and that I last saw h[illegible] alive on 3-4-1946.

Immediate cause of death Acute heart failure — Duration

Due to Coronary thrombosis

Due to Arteriosclerotic & Hypertensive Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hosp. Date signed 3-4-46

VS 150

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G380[illegible]9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2352 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2352 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Poloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Abraham
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1881
8. AGE: Years 65 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Reben
13. Birthplace Russia
MOTHER 14. Maiden Name Esther
15. Birthplace Russia
16 (a) Informant Abraham Poloway
(b) Address 2352 Frederick Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-46 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard
18 (a) Funeral director Jack Lewis Inc
(b) Address [illegible] Baltimore St
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-1946, at 2 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1946, to March 5 1946 and that I last saw h[illegible] alive on March 5 1946.

	Duration
Immediate cause of death Acute Cardiac Failure	1 hr
Due to Broncho-Pneumonia	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] Goldman MD
Address 19[illegible] Wealth Ave Date signed 3/5/46

Huntington Williams, MD

VS 190

G38060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

G38060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 E. Hoffman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH MARIE OTTO

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	213-20-0154

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Harry Otto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1885

8. AGE: Years	Months	Days	If less than one day
60	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Saleslady
11. Industry or business Schulte United. Lex.

FATHER
12. Name John W. Gebhard
13. Birthplace Germany

MOTHER
14. Maiden Name Mary L. Boram
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Leroy M. Otto-son
(b) Address 2114 E. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Local registrar) (b) MAR 5 1946 Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH Mar. 3 1946, at 3.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1944 to Mar 3 1946, and that I last saw her alive on Mar 2 1946.

Immediate cause of death Carcinoma G.I. tract — Duration 7

Due to

Due to,

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1206 E. Preston St. Date signed 3/4/46

X

G38061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38061
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME William Brandt (WILLIAM BRANDT)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Elizabeth Oed Callie Laksahn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1875

8. AGE: Years 90 | Months 4 | Days 7 10 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Insurance Salesman

11. Industry or business Rial Jackson Co

FATHER
12. Name ? Brandt
13. Birthplace Germany

MOTHER
14. Maiden Name ? Wick
15. Birthplace Germany

16 (a) Informant Mrs. Wm. H. Berends (daughter)
(b) Address 4302 Arabia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 5 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1946, 2:4 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Jubinski M.D.
Medical Examiner.
Date signed 3/3/46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G38062 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3611 Windsor Mill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Windsor Mill Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Aubrey Edwards

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Julia E. Hamp
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 6, 1886

8. AGE: Years 59 | Months 7 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business O. P. A.

FATHER
12. Name George W. Edwards
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Adelaide Carver
15. Birthplace Baltimore, Md.

16 (a) Informant Julia Hamp Edwards
(b) Address 3611 Windsor Mill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/46 (month) (day) (year)
(c) Cemetery ~~Crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 MAR 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Address Medical Arts Bldg. Date signed

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1946 to Mch 2 1946, and that I last saw h[illegible] alive on Mch 2 1946

	Duration
Immediate cause of death: Coronary Thrombosis	2 hrs.
Due to: —	
Due to: —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. Delaney Thomas, M. D.

C38063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. C38063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 Maryland Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 2y 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Katherine M. Goss

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: John
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): June 3 1894
8. AGE: Years 51 | Months 9 | Days 1 | If less than one day: — hr. — min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: housework
11. Industry or business: at home

FATHER
12. Name: Andrew Hopkins
13. Birthplace: Germany

MOTHER
14. Maiden Name: Annie Mc. Mann
15. Birthplace: Germany

16 (a) Informant: Mr John. Goss
(b) Address: 2412 Md Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Rt 40 Eastern Highway

18 (a) Funeral director: John F. Howard Son
(b) Address: 901-07 Gilmor St.

19 (a) MAR 5 1946 Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1946 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4/16 1945 to May 4 1946. and that I last saw h[illegible] alive on Feb 28 1946.

Immediate cause of death: Cardiac Insufficiency — Duration: 4 hrs
Due to: Fatty infiltration of heart. — Duration: not known
Due to: — Duration: 2 years
Other Conditions: Carcinoma Uterus + abdomen
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature: Raymond Goss M. D.
Address 2438 Maryland Ave Date signed March 4 1946

VS 150

1 & 92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 D

G38064 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland St Agnes Hospital
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months 20 days (M.)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen E. Wild

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife William F. Wild
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 13, 1909

8. AGE: Years	Months	Days	If less than one day
36	9	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Albert G. Snyder
13. Birthplace Martinsburg W. Va.

MOTHER
14. Maiden Name Clara E. Roberts
15. Birthplace Martinsburg W. Va.

16 (a) Informant Mr. William F. Wild
(b) Address 316 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Frederick H. Cole
(b) Address 1200 W. Lombard St

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1946 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 3/1 1946 and that I last saw he alive on 3-1- 1946 (eu)

Immediate cause of death: Cardio vascular collapse — Duration

Due to Hypertension

Due to

Other Conditions Hodgkins disease June 1945
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 33 W. Mulberry St. Date signed

VS MAR 5 1946 Huntington Williams, M.D. Thomas J. Mulleein, M.D. 95C

G38065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G38065 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Harwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Harwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARK EDWIN MAYBERRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	212-16-5748

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sadie House Mayberry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1890

8. AGE: Years	Months	Days	If less than one day
55	6	9	hr. min.

9. Birthplace Cumberland Co., Pa.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Alban Tractor Co.

FATHER
12. Name Jeremiah Mayberry
13. Birthplace Pa.

MOTHER
14. Maiden Name Lucinda Souders
15. Birthplace Pa.

16 (a) Informant Mrs. Sadie H. Mayberry
(b) Address 519 Harwood Ave.

17 (a) Burial (b) Date thereof 3/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 5 1946 (b)
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4, 1946 at 7 35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 3 1946 to Mar 4 1946 and that I last saw h/m alive on Mar. 3 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl H. Benson, M.D.
M. D.
Address 511 York Rd Date signed 3/5/46

VS 150

Huntington Williams, M.D.

G38066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G38066
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3525 Liberty Hgts. Ave.
(c) Hospital or institution:

15-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Liberty Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA RAUCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1865

8. AGE: Years	Months	Days	If less than one day
80	3	29	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Christopher Rauch
13. Birthplace Germany

MOTHER
14. Maiden Name Mary (unknown)
15. Birthplace Germany

16 (a) Informant Mr. George W. Golden, Jr.
(b) Address 3525 Liberty Hgts. Ave.

17 (a) Burial (b) Date thereof 3/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 5 1946 (b) Huntington Williams, Jr.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 3, 1946, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to March 3 1946 and that I last saw h-- alive on March 2 1946

Immediate cause of death Coronary Thrombosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm D Rauch
Address 701 N. Howard St Date signed 3/4/46

X

G38067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83 A G38067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3330 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Estella Kaufman

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race Wh

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry Kaufman

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1883

8. AGE: Years 62 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Godfrey Kircher
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Veronica Lang
15. Birthplace Germany

16 (a) Informant Frederick Kircher
(b) Address 2772 W. North Ave., Baltimore 16 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md. for Williams, M.D.

MAR 5 1946

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 March 1946 at 8.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Mar 1946 to 2 Mar 1946, and that I last saw h[illegible] alive on 2 Mar 1946

Immediate cause of death Apoplectic Stroke — Duration 5 hours

Due to Hypertension, Arterial — 10 Yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius W. Bell M. D.
Address Date signed

VS 150

For B. L. R. Davis, by Howard J. Williams, M. D.

PRESS WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B G38068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5115 St. Georges ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER KINSLEY FORD

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ora B. Ford.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-9-88.

8. AGE: Years 57 | Months 8 | Days 24 | If less than one day: hr. min.

9. Birthplace Md (Balto.) (Town, county, and state)

10. Usual Occupation accountant

11. Industry or business Retail Stores, Inc.

FATHER
12. Name John B. Ford.
13. Birthplace Md. (St. Mary's Co.)

MOTHER
14. Maiden Name Roxanna Kinsley
15. Birthplace Md. (Balto.)

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 5 1946 (Date rec'd by local registrar) (b) With attending M.D.

Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 3. 3. 1946, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1946 to 3. 3 1946 and that I last saw him alive on 3-3 1946

Immediate cause of death Cerebral Embolus — Duration

Due to 2

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice B. Visscher M. D.
Address Johns Hopkins Hospital Date signed 3 Mch. 46

VS 150

FORCE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38069

G38069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4007 Chatham Rd.
(c) Hospital or institution: 15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Chatham Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK EDWARD GAEBLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alice E. Gaebler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1877

8. AGE: Years	Months	Days	If less than one day
68	7	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Fred. E. Gaebler & Co.

FATHER
12. Name Charles Gaebler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Christina Lauterbach
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Alice Gaebler
(b) Address 4007 Chatham Rd.

17 (a) Burial (b) Date thereof 3/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lotraine Pk. Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 5 - 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946; at 1 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 8 1945 to Mar 3 1946 and that I last saw h[illegible] alive on 2/28/1946

Immediate cause of death	Duration
Coronary thrombosis	3 mos.
Due to Coronary occlusion	2 mos.
Due to arteriosclerosis	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Lauterbach M. D.
Address 6 Rundel St Date signed 3/4/46

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38070

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2553 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 W 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora May Dey.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife Ernest W. Dey.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1882

8. AGE: Years	Months	Days	If less than one day
63	9	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Homemaker
11. Industry or business

FATHER
12. Name George H. Hines
13. Birthplace Maryland.

MOTHER
14. Maiden Name Annie Yingling
15. Birthplace Maryland

16 (a) Informant Charles Dey.
(b) Address 417 W 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Edmund F. Donovan
(b) Address 3646 Edmondson Ave.

19 (d) MAR 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1946, at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to March 1946 and that I last saw her alive on March 1946

Immediate cause of death	Duration
Cerebral Clot	24 hrs
Due to Arteriosclerosis	4 yrs.
Due to	
Other Conditions Cerebral Clot	Dec 1944

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Leonard H. Hoff M. D.
Address 2020 E. Cleary Date signed 3/5/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

R G38071

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Singer Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Singer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Pohlback.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Arthur W. Pohlback

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 11, 1889

8. AGE: Years	Months	Days	If less than one day
56	8	22	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Talbott.
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Green.
15. Birthplace Virginia

16 (a) Informant Arthur W. Pohlback.
(b) Address 714 Singer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6/46 (month) (day) (year)
(c) Cemetery or crematory Middletown
Location Frederick Co Md.

18 (a) Funeral director Chenoweth & Sonneman
(b) Address 3615-17 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946 at 4 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to March 3 1946, and that I last saw her alive on March 3 1946

Immediate cause of death	Duration
Diabetes Mellitus	5 yrs.
Diabetic Coma	2 days.
Due to	
Due to	
Other Conditions Hypertension CVD	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Linnard M. D.
Address 814 Dallam Date signed 3-7-46

VS 150 MAR 5 - 1946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

638072 55 E R 638072

638072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 Admiral Blvd - 11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM PHILLIPS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine B Phillips 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4-1872

8. AGE: Years	Months	Days	If less than one day
73	3	0	hr. min.

9. Birthplace South Wales
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Nat'l Distillery

FATHER
12. Name William Phillips
13. Birthplace South Wales

MOTHER
14. Maiden Name Sarah Davis
15. Birthplace S. Wales

16 (a) Informant Mrs. Catherine P Phillips
(b) Address 30 Admiral Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd.

19 (a) (registrar) (b) Registrar

MAR 8 1946

Huntington Williams, M.F

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1946, to 3/4 1946, and that I last saw h[illegible] alive on 3/4 1946.

Immediate cause of death	Duration
Metastatic Carcinoma (From Lung)	?
Due to	
Due to	
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Blackburn M. D.
Address South Bal. Date signed 3/4/46

X General Hosp

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38073 G38073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 544 N Polaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 544 N Polaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles M Herrington

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-66-9743

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife J Herrington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25-1890

8. AGE: Years	Months	Days	If less than one day
55	5	9	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Superintendent
11. Industry or business Bottle Exports.

FATHER
12. Name John Herrington
13. Birthplace Del

MOTHER
14. Maiden Name Emma A Moore
15. Birthplace Del

16 (a) Informant Grace Miller
(b) Address 544 N Polaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7 46 (month) (day) (year)
(c) Cemetery or crematory Camden Del
Location 100 F Courtesy Powell

18 (a) Funeral director Charles Powell
(b) Address 2427 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 5 - 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4th 1946, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22-1945 to 2-12-1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Occlusion	
Due to Coronary Sclerosis	1 yr
Due to Hypertension of Arterio-Sclerosis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Solomon Herman M. D.
Address 424 Eutaw Place Date signed 3-4-46

X

LILLIAN WARREN GREEN. G38074

G38074 48267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 760 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Warren Green.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-10

8. AGE: Years	Months	Days	If less than one day
35.	2	10	hr. min.

9. Birthplace B. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Warren
13. Birthplace B. C.

MOTHER
14. Maiden Name Julia Allen
15. Birthplace B. C.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 7 46 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY CEM.
Location A. A. County Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 5 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1946, to March 4 1946, and that I last saw her alive on March 4 1946

Immediate cause of death: Cancer of uterus Loft N. Ill — Duration: 7

Due to

Due to

Other Conditions: Carcinomatosis abscess bilateral

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: Confirmed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Nolan M. D.
Address 906 N Broadway Date signed 3-7-46

X

Please write plainly in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G38075 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 W. Monument
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McFarland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/46

8. AGE: Years | Months | Days: 8 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Jan Pors MacFarland
13. Birthplace Leicester England

MOTHER
14. Maiden Name Louise
15. Birthplace Farville N. D.

16 (a) Informant Jan Pors MacFarland
(b) Address 225 W. Monument St

17 (a) Buriel (b) Date thereof 3-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Charles W. Leatherbury
(b) Address 702 McHenry St

19 (a) (b)
(Date received by local registrar) (Registrar)

MAR 5 1946 Huntington Millicent

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1946 to 3/4 1946 and that I last saw him alive on 3/4 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address 1 E. Mt. Vernon Pl. Date signed 3/4/46

X

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

638076 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 Annapolis Exp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 Annapolis Exp
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F Grace

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1542

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 - 1892

8. AGE: Years	Months	Days	If less than one day
53	2	10	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name John Grace
13. Birthplace Md

MOTHER
14. Maiden Name Elze
15. Birthplace Md.

16 (a) Informant Family Records
(b) Address 2033 Annapolis Exp

17 (a) Burial (b) Date thereof 3/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Medford Rural Cem
Location Walker Blvd

18 (a) Funeral director Edw Taylor
(b) Address 2339 Walker Blvd

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 5 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 1946, at 1:27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1946, to Mar 4 1946, and that I last saw him alive on Mar 4 1946

Immediate cause of death: Lobar Pneumonia — Duration 2/28/46

Due to

Due to

Other Conditions Myocarditis — 3

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl A Hocking M. D.
Address 13 N W Lombard St Date signed 3/4/46

G38077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38077 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Monumental Life Insurance Co
(b) Street address Charles and Chase Sts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aloysius Rosendale

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-6563

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Helen M.
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 15-1876

8. AGE: Years	Months	Days	If less than one day
69 70	8 7	17 19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Insurance Man
11. Industry or business Monumental Life Ins Co

FATHER
12. Name Christopher T Rosendale
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Rosemeier
15. Birthplace Baltimore - Md.

16 (a) Informant Dorothy K. Rosendale
(b) Address 1718 W. Lombard St.

17 (a) Burial (b) Date thereof Feb. 7-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Baltimore Md.

18 (a) Funeral director Thomas J. Kenny Inc
(b) Address 1600 + Gilmor Sts.

19 (a) MAR 5 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1946, at 4:20 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3/7/46

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The

G38078 G38078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 834

Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. The age is especially important. Physicians: please w

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 Harlem ave
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mable B. Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a). Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Charles Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1893

8. AGE: Years	Months	Days	If less than one day
53	1	16	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Noah Lindsey
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Susie Bradford
15. Birthplace Richmond Va

16 (a) Informant Maurice L. Moore
(b) Address 851 Harlem ave

17 (a) Burial (b) Date thereof 3-8-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 402 N Mount Street

19 (a) 3-5-1946 (b) [illegible]
(Date received by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/46 19 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/46 to 3/3/46 and that I last saw h alive on 19

Immediate cause of death	Duration
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1131 Hart Date signed

Ward 6.

G38079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 156 B G38079
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Llewellyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Pickett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 33 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Pickett
13. Birthplace S. C.

MOTHER
14. Maiden Name Emma Starks
15. Birthplace S. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Winnsboro
Location South Carolina

18 (a) Funeral director Adolphus Holstead
(b) Address 918 Druid Hill Ave

MAR 5 - 1946 (b) Huntington Hillcrest, Md.
(Date) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Dec 1945 to 1 March 1946 and that I last saw h[illegible] alive on 1 March 1946.

Immediate cause of death Weakness of respiratory muscles — Duration 3 yrs
Due to myasthenia gravis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation June 1944
Major findings of operation Thymectomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Grob M. D.
Address J. H. H. Date signed 2 March 46

VS 150

For D. W. B. Hedrick, by Howard L. Mallis, M.D.

Every item of information should be carefully supplied. The cause of age is especially important. Physicians: please write the causes of death clearly and legibly. CAUTION—THIS CERTIFICATE, WITH UNFADING INK.

G38080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G38080

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hosp. 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. Carolina St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles McNair

3 (b) If veteran, name war

3 (c) Social Security Account No. 240-24-8244

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 25 | Months | Days | If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Nancy McNair
(b) Address Philad., Pa.

17 (a) Burial (b) Date thereof 3-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurensburg
Location North Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 5 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found at 2-26-46 4:40 P.M.
(b) Where did injury occur? Harbor: 800 Blk S. Caroline St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no.
(d) Means of injury Found drowned.

23. Signature Benedict Catarelle M.D.
Medical Examiner.
Date signed 2-26-46

VS 151

G38081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

G38081 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Ridgely St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Ridgely St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice S. Sloss

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Wm. J. Sloss
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1875

8. AGE: Years	Months	Days	If less than one day
71	—	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Robert Eades
13. Birthplace England

MOTHER
14. Maiden Name Mary (nee ?)
15. Birthplace England

16 (a) Informant Wm. J. Sloss (Husband)
(b) Address 1011 Ridgely St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Co. Md.

18 (a) Funeral director P. H. Edward Evans
(b) Address 1400 S. Charles St.

MAR 5 - 1946 (Date received by registrar) Huntington Wilkinson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1946 at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1946 to 3-4 1946 and that I last saw h-- alive on 3-4 1946

Immediate cause of death — Duration

Cerebral Hemorrhage — 7 days

Due to Hypertensive Cardio Vascular Disease — unk

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Joseph Vaccaro, M.D.
Address 1709 Washington Blvd Date signed 3/5/46

VS 150

G38082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 GB8038

Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Greene
(b) Street address (1612 Harlem Ave)
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balti City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Boulcher

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	

6 (b) Name of husband or wife Prince
6 (c) If alive; give age 39 years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
39	—	—	hr. ——— min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business —

FATHER
12. Name Williams (last name)
13. Birthplace Macon, Ga

MOTHER
14. Maiden Name — Anna
15. Birthplace Ga.

16. (a) Informant Husband.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18. (a) Funeral director Mrs Katie R. Williams
(b) Address 22 E. Schroeder St.

MAR 5 - 1946

19 (a) ——— (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1946, at 2.58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1946, to 3-1 1946, and that I last saw her alive on 3-1 1946

Immediate cause of death Right sided heart failure (Probable)

Duration

Due to Rheumatic Cardiac Vascular disease

Due to Acute Rh. Fever when young

Other Conditions Late, latent Syphilis

(Include pregnancy within 3 months of death)

Date of operation ———

Major findings of operation ———

of autopsy ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Dorcas Clark M. D.
Address University Hospital Date signed 3-2-46

93C

Ethel Hall

G38083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G38083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3 (a) FULL NAME Ethel Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-8-20.

8. AGE: Years 25 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fait Hall
13. Birthplace N.C.

MOTHER
14. Maiden Name Helen allen
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director
(b) Address

19 (a) Filed MAR 5 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 3 1946 at 7 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1946 to 3-3 1946 and that I last saw h[illegible] alive on 3 3 1946.

Immediate cause of death Pneumonia, Lobar lungs — Duration 5 Days

Due to Pneumococci

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Hart M. D.
Address JHH Date signed 3 Mar 46

X

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1938 108

Registered No. G38084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 545 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Wainwright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1904

8. AGE: Years	Months	Days	If less than one day
42	-	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Stevenson Wainwright
13. Birthplace Md.

MOTHER
14. Maiden Name Nettie Gaddis
15. Birthplace Md.

16 (a) Informant Mrs. Lestie Wainwright
(b) Address 700 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-46 (month) (day) (year)
(c) Cemetery or crematory
Location Whitehaven, Maryland

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b) Date recd by registrar Huntington Williams, M.D.

MAR 5 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1946, to 3/2 1946, and that I last saw h.i.a. alive on 3/2 1946.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to Bacterial Infection	
Due to	
Other Conditions Myocardial Failure (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. Franklin Littleton, M.D.
Address 1423 Perm. Ave. Date signed M 3 D 4 46

X

G38085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B Registered No. G38085

Abroad: 55. Canyon Creek

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Georgia (b) County
(c) City or town East Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Wadley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Coy Thames

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/1905

8. AGE: Years 40 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Samuel Thames
13. Birthplace Georgia

MOTHER
14. Maiden Name Mattie Barfield
15. Birthplace Georgia

16 (a) Informant W. S. Carmichael
(b) Address Atlanta Georgia

17 (a) Thames (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Evon Cem
Location Fulton Co. Georgia

18 (a) Funeral director Wm Cook Sons
(b) Address 217 St Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MAR 5 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of Liver

Due to

Other Conditions Cardiac hypertrophy, slight

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 3-3-46

G38036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 G38036

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Kepler Addison

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary Francis TODD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 1871

8. AGE: Years	Months	Days	If less than one day
75	0	11	hr. min.

9. Birthplace Alexandria Va
(Town, county, and state)
10. Usual Occupation Lenhart Clerk
11. Industry or business U. S. Govt

FATHER
12. Name Walter Dulany Addison
13. Birthplace Natchez Miss

MOTHER
14. Maiden Name Mary Helen Grant
15. Birthplace New Orleans La

16 (a) Informant Mrs Elizabeth M Waller
(b) Address 2100 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Hartman & Son
(b) Address 1370 Pine St

19 MAR 5 - 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1928 to Mar 4 1946 and that I last saw h[illegible]ive on 3/4 1946.

Immediate cause of death: Myocarditis
Arterio-Sclerosis — Duration: Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Woody M.D.
Address 1403 Park Ave Date signed 3/4/46

VS 150

Huntington Williams, M.D.

G38087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 53

G38087 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: The Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5108 Ivanhoe Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Grace L. Tillo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr Karl Frank Tillo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21st 1896

8. AGE: Years 49 | Months 2 | Days 13 14 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank Swabb

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Emma Black

15. Birthplace Pennsylvania

16 (a) Informant Karl F. Tillo

(b) Address 5108 Ivanhoe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Prospect Hill

Location Towson Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) MAR 5 - 1946 (Date filed by registrar) Washington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946 to Mar 4 1946 and that I last saw him alive on Mar 4 1946

Immediate cause of death Melano-sarcoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Mar 3 1946

Major findings of operation Melano-sarcoma

of autopsy

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Speed III

Address Union Memorial Hospital 3/4/46

correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. The ... PRINTED, WITH UNFADING INK.

VS 150

X 1 pad

SARIS

G38038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38038

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. John Saris

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-01-8541

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Penelope

6 (c) If alive, ~~divorce~~ Yes years

7. Birth date of deceased (mo., day, yr.) Dec. 27 1893

8. AGE: Years	Months	Days	If less than one day
52	2	7	hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Restaurant Mgr.

11. Industry or business

FATHER
12. Name Constantine
13. Birthplace Greece

MOTHER
14. Maiden Name Angelos
15. Birthplace Greece

16 (a) Informant Wife Penelope
(b) Address 1804 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar (month) (day) 1946 (year)
(c) Cemetery or crematory Greek Orthodox Ch
Location Wilson Mill Rd

18 (a) Funeral director Martin W.C. Diffenbaugh Sons
(b) Address Lombard + Arnold St

19 (a) (Date rec'd by registrar) MAR 5 1946 (b) Registrar for Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, 7:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1946 to 3/4 1946. and that I last saw h/m alive on 3/4 1946.

Immediate cause of death: Uremia

Due to Chronic Nephritis

Due to

Other Conditions Hypertension C-V-D

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Calvert, M.D.
Address St Agnes Hosp Date signed 3/5/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

Registered No. G38089

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write "RURAL" and give town)
(d) Street No. 102 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Rhoades

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Fem.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 17 1933

8. AGE: Years 12 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation SCHOOL GIRL

11. Industry or business

FATHER
12. Name James Edward Rhoades
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lillian Miller
15. Birthplace Baltimore, Md.

16 (a) Informant LILLIAN RHOADS (MOTHER
(b) Address 102 N. WOLFE ST.

17 (a) BURIAL (b) Date thereof MAR. 6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lilly & Zeiler inc
(b) Address 403 S. WOLFE ST.

19 (Date rec'd by registrar) MAR 5 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4 1946 at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1946 to 3-4 1946 and that I last saw her alive on 3-4 1946

Immediate cause of death: Diphtheritic Myocarditis — Duration

Due to Diphtheria

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jehelciah Sprogins

Address Sydenham Hosp. Date signed 3-9-46

G38090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G38090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LOMBARD & GREEN
(c) Hospital or institution:
MD.UN.HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE ESSEX MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. HYDE PARK
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD H.BOSTWICK

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife GERTRUDE BOSTWICK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR.27 1897

8. AGE: Years 48 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation AUTO.MECHANIC.

11. Industry or business

FATHER
12. Name HARRISON BOSTWICK
13. Birthplace MD.

MOTHER
14. Maiden Name LULA WUSTLAND
15. Birthplace MD.

16 (a) Informant GERTRUDE BOSTWICK(WIFE)
(b) Address HYDE PARK MD.

17 (a) BURIAL (b) Date thereof MAR.6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S.WOLFE ST.

19 (a) MAR 5 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4-46 19 , at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12N 3-4-46 19 12:30AM 3-4 19 46, and that I last saw him alive on 3-4 19 46

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L.M. Marx M. D.
Address University Hosp. Date signed 3-4-46

VS 150

correct age is especially important. Physicians: please write the

G38091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38091 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.I.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-87

8. AGE: Years 50 | Months | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Wilson Stg. and Bakeshop

FATHER
12. Name Adolphus Jackson
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Williams
15. Birthplace Md.

16 (a) Informant Joseph Jackson
(b) Address 1918 Lydia Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart.
Location Germain Hill Rd. Dundalk

18 (a) Funeral director Charles R. Lane
(b) Address 802 Madison Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1946, at 8:40 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubenko M.D. (Medical Examiner.)
Date signed 3/6/46

the causes of death clearly and legibly. ... physician: please write the ... correctly supplied. The

Dr. Sawyer G38092

BALTIMORE CITY HEALTH DEPARTMENT G38092 Registered No.

CERTIFICATE OF DEATH 43a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Rosekemp Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Rosekemp Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Reitemeyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Cora Reitemeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1874

8. AGE: Years	Months	Days	If less than one day
72	1	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name August Rietemeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Zies
15. Birthplace Baltimore

16 (a) Informant Mrs. Cora Reitemeyer
(b) Address 3304 Rosekemp Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/ / 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Cemetery

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Date received MAR 5 - 1946 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1946, at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1941 to Mar 5 1946 and that I last saw h[illegible] alive on Mar 1 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Cerebral arterio-sclerosis	5 years.
Due to Essential Hypertension	5 years.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawson
Address 4808 Harford Rd. + Date signed 3/6/46

G38093 BALTIMORE CITY HEALTH DEPARTMENT G38093

CERTIFICATE OF DEATH 95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don't
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Elder Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Bowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1902

8. AGE: Years 43 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Elizabeth City, N.C.
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name Rufus Bowe
13. Birthplace Elizabeth City N.C.

MOTHER
14. Maiden Name Martha Hinton
15. Birthplace Elizabeth City N.C.

16 (a) Informant Mary Bowe Smith
(b) Address 1373 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. D. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date) registered MAR 5 1946 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946 at 12:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 3-2-46.

G38094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74

Registered No. G38094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Alto Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Alto Rd
(If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME Aaron J. Simon

3 (b) If veteran, name war ———
3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Rose J. Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1871

8. AGE: Years	Months	Days	If less than one day
74	4	—	hr. min.

9. Birthplace New York City (City, county, and state)
10. Usual Occupation Attorney at Law
11. Industry or business

FATHER
12. Name Tobias Simon
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Tobish
15. Birthplace Germany

16 (a) Informant Lawrence S. Hamburger
(b) Address 2248 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/46 (mo.) (day) (yr.)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore & Conkling Sts

18 (a) Funeral director Ahern & Co
(b) Address 1132 Eastern Ave

19 (a) Date received MAR 8 1946 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1946, at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1945 to 3/5 1946 and that I last saw h[illegible] alive on 3/5 1946

Immediate cause of death	Duration
Acute Cardiac Dilat	24h
Due to Chronic Nephritis	10 Jrs
Due to Leukemia	?
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Zeller M. D.
Address 2218 Eutaw Pl Date signed 3/6/46

G38095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G38095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Greene St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 North Greene
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Keyser (Kaiser)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1868

8. AGE: Years 77 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Horse shoer Retired

11. Industry or business

FATHER
12. Name Henry Kaiser
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Geo. J. Kaiser
(b) Address 19 E. Appenzeller Rd

17 Burial (Burial, cremation, or removal) (b) Date thereof 3/8/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Wilbur Corkran
(b) Address 1217 E. Fayette St. Baltimore, Md.

19 (a) (Date received by Registrar) (b) Registrar

MAR 8 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/46 19 , at 1:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Davis, M.D. M.D.
Medical Examiner.
Date signed 3/5/46

X

638096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B 638096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Marx Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J Dailey Jr

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 1918

8. AGE: Years 27 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Kalamazoo Mich
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Joseph Dailey Sr
13. Birthplace Belfast Ire

MOTHER
14. Maiden Name Elizabeth Kolbatch
15. Birthplace Mich

16 (a) Informant Mrs John J Dailey
(b) Address 4108 Marx Ave

17. (a) Funeral (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Cook Jr
(b) Address 1217 E Fort Ave

19 (a) MAR 6 - 1946 (b)
(Date received by Registrar) Registrar

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1946, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/5/46

X

M. D. B. 1268-9

G3809 HEALTH DEPARTMENT—CITY OF BALTIMORE G3809

CERTIFICATE OF DEATH 55E

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3830 Hickory St. 13 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME SEVILLA R. ROSER

(a) Residence: No. 3830 Hickory St., 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, ~~Married~~, Widowed, ~~or Divorced~~ (write the word)
F	W	Widowed

5a. If married, widowed, or divorced: ~~HUSBAND~~ of (or) WIFE of Wesley Roser

6. DATE OF BIRTH (month, day, year) Jan. 25. 1868

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	1	10	

OCCUPATION.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Penna.

FATHER

13. NAME John Rohrbaugh

14. BIRTHPLACE (city or town) (State or country) Penna.

MOTHER

15. MAIDEN NAME unknown

16. BIRTHPLACE (city or town) (State or country) unknown

17. INFORMANT Charles B. Wright

(Address) 3836 Hickory Ave

18. BURIAL, ~~CREMATION~~, OR REMOVAL

Place Eden Park Date Oct. 3/8/1946

19. UNDERTAKER H. G. Sisler

(Address) Eden Park, Balto

20. FILED MAR 6 - 1946 ~~Registrar~~ Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3/5 1946

22. I HEREBY CERTIFY, That I attended deceased from Jan 2 1946 to March 5 1946.

I last saw h[illegible] alive on March 5 1946 Death is said to have occurred on the date stated above, at 515P m.

The principal cause of death and related causes of importance were as follows:

a Carcinoma Parotid gland — Date of onset ?

Other contributary causes of importance:

Arteriosclerosis CVD — ?

Name of operation ... Date of ...

What test confirmed diagnosis? Clinical Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? Not If so, specify ...

(Signed) Lawrence Steinmayer M. D.

(Address) 3711 Bailey Rd

OCCUPATION is very important. See instructions on back of certificate.

G38098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1942 G38098 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John St & Lafayette Ave.
(c) Hospital or institution: Woman's Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900, N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA SOBER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MORRIS SOBER

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) april ? 1885

8. AGE: Years 60 | Months 11 | Days ? | If less than one day ... hr. ... min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name IRA WEINSTEIN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name RACHEL ?
15. Birthplace RUSSIA

16 (a) Informant Dr. LOUIS SOBER. D.D.S.
(b) Address 5900 TONQUIL AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-46 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location Jerome Mill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (Filed by registrar) MAR 6 - 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 6th 1946 at 3 5-5-46 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4/46 19... to 3/6 1946 and that I last saw h.E.R alive on MARCH 6 1946.

	Duration
Immediate cause of death RESPIRATORY AND CARDIAC FAILURE	?
Due to CARDIAC ASTHMA & AORTIC & MITRAL INSUFF.	?
Due to INFECTIOUS NATURE	6 days?
Other Conditions AORTIC & MITRAL INSUFFICIENCY	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature X. J. Arias M.D.
Address Woman's Hospital Date signed 3/6/46

G38099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38099 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTED, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Belvedere & Green Spring Ave

(c) Hospital or Institution: Lenndale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Herman Muthlest

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Esther —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

FATHER 12. Name

13. Birthplace Russia

MOTHER 14. Maiden Name

15. Birthplace Russia

16 (a) Informant Lenndale Nearda

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location

18 (a) Funeral director Jos. Segura Inc

(b) Address 1429 E. Balto. St.

19 (a) MAR 6 (Date rec'd by registrar) (b) 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946, at 1.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1943 to 3-5 1946 and that I last saw h. alive on 3-5 1946

Immediate cause of death Ch. card. ren. disease

Generalized arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund Levin, M.D.

Address Lenndale Date signed 3/5/46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38100 1946 G38100 No.

G38100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 No Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 No Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Fidel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
53				

9. Birthplace Russia (town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie
15. Birthplace Russia

16 (a) Informant Anna Fidel
(b) Address 1420 No Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) (b) Signature

MAR 6 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-1946, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1946, to March 5 1946 and that I last saw h[im] alive on March 4 1946.

Immediate cause of death	Duration
Coronary occlusion	3 days
Due to arterio-sclerosis	10
Due to Hypertension	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frank Levinson M. D.
Date signed 3/8/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G38101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 159

G38101 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 W Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 W Pratt St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Foltus Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1946

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Benjamin Franklin Williams
13. Birthplace Balto City

MOTHER
14. Maiden Name Willetta Franklin Zapp
15. Birthplace Baltimore City

16 (a) Informant W. F. Williams
(b) Address 836 W Pratt St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School MAR 5 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 6 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 March 1946, at 1:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 March 1946 to 4 March 1946, and that I last saw him alive on 3 March 1946.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen M. D.
Address 206 S. Gilmor St Date signed 3-4-46

5334 X

G38102 G38102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 184

Registered No.

Please write the causes of death clearly and legibly. The necessary supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Artis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-1904

8. AGE: Years 41 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Willis Artis

13. Birthplace Va

MOTHER 14. Maiden Name Gertrude Hayman

15. Birthplace

16. (a) Informant Mamie Shaird

(b) Address 1527 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 9 46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Park

Location Baltimore Md

18 (a) Funeral director Williams & Jackson

(b) Address 916 Pennsylvania Ave

19 (a) MAR 6 - 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946, at 10 05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Peritonitis

Due to Gun shot wound of Abdomen.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2/19/46 19 10 15 P.M.

(b) Where did injury occur? 1529 W. Lexington St

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Gunshot wound

23. Signature Benedict Skotarelis M.D. Medical Examiner.

Date signed 3-5-46

VS 151

G38103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1640

G38103 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital S
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Mott Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Walter Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-25-1880

8. AGE: Years 65 | Months 2 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Charles Co Md (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business Jno Hopk Hosp

FATHER
12. Name Richard Small
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Gray
15. Birthplace Md

16 (a) Informant Olanzo Tilghman
(b) Address 515 Carrollton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 7 46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) MAR 6 - 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946 at 5-10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-3-46 at P. M.
(b) Where did injury occur? 415 Mott st.
(c) Did injury occur at home, on farm, industrial place, in public place? House While at work? no
(d) Means of injury Self-inflicted gunshot.

23. Signature Benedict Stasiulis M.D. Medical Examiner.
Date signed 3-4-46.

VS 151

correct age is especially important. Physicians: please write the

G38104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G38104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town Berlin
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Ryclie Pruitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alfred Pruitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas James
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Coffin
15. Birthplace Md

16 (a) Informant Mrs A. Burbage
(b) Address Berlin Md

17 (a) Burial (b) Date thereof Mch 7 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem
Location Berlin Md.

18 (a) Funeral director John A. Gruber Funeral Home
(b) Address 140 Baltimore Place

19 (a) Filed MAR 6 - 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1945 at 4 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1945 to 3/5 1945 and that I last saw h[illegible]R alive on 3/5 1945

Immediate cause of death Cardio-Resp. failure — Duration

Due to Acute Vas-Motor Collapse

Due to Post-operative Shock.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb 27 1945

Major findings of operations: Carcinoma of stomach to liver, Gall bladder adherent to stomach & liver

Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. Hart M.D.
Address Community Hospital Signed 3/7/45

VS 150

X

G38105

G38105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 942

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 Pickwick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Pickwick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME MILDRED BULL TSCHUDY

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard A. Tschudy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 2, 1890

8. AGE: Years: 56 | Months: 0 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Irving Bull
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden Name: Stella Hood
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Howard A. Tschudy
(b) Address: 2506 Pickwick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 6 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/46 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: C. J. Labriola M.D. Medical Examiner.
Date signed 3/7/46

X

VS 151

G38106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1312

G38106

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Eutaw Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** WILLIAM W. STANTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19-1872

8. AGE: Years	Months	Days	If less than one day
73	11	13	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James Stanton
13. Birthplace England.

MOTHER
14. Maiden Name Elizabeth Appel
15. Birthplace Germany

16 (a) Informant Anita G. Stanton
(b) Address 7 N. Fuzuway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave

18 (a) Funeral director John A. Nolan
(b) Address 300 E. Balto St.

19 (a) Date rec'd by MAR 6 - 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 March 1946 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Feb. 1946, to 4 Mar. 1946, and that I last saw h im alive on 4 Mar. 1946.

	Duration
Immediate cause of death Uremia	
Due to Chronic Glomerular Nephritis	
Due to	
Other Conditions Arteriosclerotic CV disease; Bleeding Peptic Ulcer. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry F. Wilson Jr. M. D.
Address St. Joseph's Hosp Date signed 4 Mar 46

VS 150

G38107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 a

G38107 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The necessary item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 N. Highland a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Highland a (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Grupp

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13-1880

8. AGE: Years 65 | Months 6 | Days 20 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Grupp
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Hiresver
15. Birthplace Penna

16 (a) Informant Mrs. A. H. Grupp
(b) Address 2527 Forst. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director John A. McGann
(b) Address 3000 E. Balto. St

19 (a) Date received by Local Registrar MAR 6 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Oct 1945 to 3/2 1946, and that I last saw h[illegible] alive on 3/2/1946.

Immediate cause of death Carcinoma of Esophagus — Duration 8 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Gardner
Address 3400 E. Balto St Date signed 3/4/46

G38108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

G38108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Burke Brzoskowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Rose Burke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Felix Burke
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Rose Burke
(b) Address 2501 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozaagowski
(b) Address 1930 Eastern Ave.

19 (a) (Date received by local registrar) MAR 6 1946 Huntington Williamsport

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1946, at 5 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1946 to 3-5 1946 and that I last saw him alive on 3-5 1946.

Immediate cause of death Cardiac Resp. failure — Duration

Due to Ca of Larynx & metastasis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Autopsy

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Strahan M.D.

Address Mercy Hosp Date signed 3-5-46

X

If any item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38:09 — BALTIMORE CITY HEALTH DEPARTMENT — G38:09

CERTIFICATE OF DEATH 13B

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement, omission or concealment of facts or information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Roller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1889

8. AGE: Years 56 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Penn (Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Lucy Roller
15. Birthplace Penn

16 (a) Informant Lillie Roller
(b) Address 1117 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St

19 (a) (b)
Filed by (Signature or Initials) Registrar

MAR 6 — 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 5 1946 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1946 to 3-5 1946 and that I last saw h[illegible] alive on 3/4 1946

Immediate cause of death: Pulmonary Embolism — Duration

Due to /

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Hatcher M. D.
Address 1725 Park Ave Date signed 3/6/46

G38110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G38110

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Forest Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE SEIDENMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Joseph Seidenman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1872

8. AGE: Years	Months	Days	If less than one day
74	7	18	hr. min.

9. Birthplace Warsaw.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harris Seidenberg,
13. Birthplace Warsaw.

MOTHER
14. Maiden Name Bella Ferman,
15. Birthplace Warsaw.

16 (a) Informant Mrs. Jacob Dashew (Daughter)
(b) Address Temple Garden Apts.

17 (a) Burial (b) Date thereof 3.7.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place.

MAR 6 1946 (Date received by registrar) (b) Huntington Millstead, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th. 1946, at 9.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1945, to March 5 1946, and that I last saw h~~e~~ alive on March 5 1946.

Immediate cause of death	Duration
Carcinoma of Gall Bladder & Liver	6 months
Due to ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael A. Abrams M. D.
Address 1820 Eutaw Place. Date signed March 6 '46

VS 150

G38111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38111 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 PARK AVE
(c) Hospital or institution:
CATHOLIC HOME (WOMEN) 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3YRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 PARK AVE (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA B. HEUISLER.

3 (b) If veteran, name war ---------
3 (c) Social Security Account No. ---------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles W. Heuisler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1855

8. AGE: Years	Months	Days	If less than one day
90	10 8	11	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Frederick Benzinger
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Rose Fincknaur
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Nathalie M. Merceret
(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H.W. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 6 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 5.1946 19 , at 4.A. M

21. I certify that death occurred on the date above stated; that I attended deceased from FEBY 7 1946, to MARCH 5 1946. and that I last saw her alive on MARCH 4 1946.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS FEBY 7	1946
Due to ARTERIOR SCLEROSIS	1946
Due to SENILITY.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONR

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Colantini M. D.
Address 3013 ST PAUL ST Date signed MARCH 5 1946.

X

G38112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 545 W. Conway St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 W Conway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No. 233-16-2116

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 16, 1899

8. AGE: Years 46 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace: Spotsylvania Va (Town, county, and state)

10. Usual Occupation: Laborer 1200

11. Industry or business

FATHER 12. Name: Randolph Pryor
13. Birthplace: Va

MOTHER 14. Maiden Name: Rebecca Gray
15. Birthplace: Va

16 (a) Informant: Maggie Scott
(b) Address: 545 W. Conway St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 9 1946 (month) (day) (year)

(c) Cemetery or crematory: Farmville Virginia
Location: Prince Edward County

18 (a) Funeral director: Joseph A. Lipsky
(b) Address: 409 N Mount Street

MAR 6 - 1946 (Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/1946 at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20/1946 to 3/4/1946 and that I last saw him alive on 3/1/1946

Immediate cause of death: Coronary Occlusion

Duration

Arterio sclerotic Hyperten.

Sms Cardio Vas Dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Howell Jr. M.D.

Address 601 N Carrollton Ave Date signed 3/5/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38113 G38113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2602 Foster Ave
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Foster Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Poznaniak

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-5876

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day ... hr. ... min.
67

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Wojciech Poznaniak
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Mary Poznaniak
(b) Address 2602 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J Duda
(b) Address 2829 Hudson St.

MAR 6 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4-46 19 ..., at 2 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945, to Mar 4 1946, and that I last saw h~~e~~ alive on Mar 3 1946

Immediate cause of death Carcinoma of Lung — Duration 9-12-45

Due to

Due to None

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ? at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A Schemanek M. D.
Address 842 East Ave Date signed 3-4-46

correct age is especially important. Physicians: please write the

G38114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G38114 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. WRITE IN PENCIL, WITH ONE ENTRY IN EACH SPACE.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2469 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2469 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah (Sallie) Garlic

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17, 1890

8. AGE: Years 55 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Daniel Ferguson

13. Birthplace Va.

MOTHER 14. Maiden Name Lucy Myers

15. Birthplace Va.

16 (a) Informant Robert Garlic

(b) Address 2469 Brentwood Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 7 46 (month) (day) (year)

(c) Cemetery or crematory

Location Woodlawn Va.

18 (a) Funeral director Mrs Robert A. Ellis & Dyt

(b) Address 1129 N. Carlin St.

19 (a) MAR 6 1946 (Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 1946 at noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Mar. 4 1946 and that I last saw h-r alive on Mar 4 1946

Immediate cause of death Carcinoma Stomach — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis C. Johnson M.D.

Address 2829 Guilford Ave Date signed Mar 6 1946

VS 150

X

G38115 — BALTIMORE CITY HEALTH DEPARTMENT — G38115

CERTIFICATE OF DEATH 132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1334 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1334 N. Eden St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Selby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Shedrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months — | Days — | If less than one day hr. min.

9. Birthplace Worcester Co. Md (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Migia Fields
15. Birthplace Md.

16 (a) Informant Carrie Selby
(b) Address 1334 N. Eden St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 8 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co.

18 (a) Funeral director Lottie Sipes
(b) Address 1600 Ashland Ave

19 (a) MAR 6 1946 (Date rec'd by registrar) Huntingtown Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946, at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 5 1946 and that I last saw h.e.r. alive on March 4 1946

Immediate cause of death: Cerebral Hemorrhage. — Duration: 3 days.

Due to: Hypertension — 7

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Burnwell M. D.
Address 121 Conquest Date signed 3-6-46

VS 2

S1718 X ✓

638116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111C

Registered No. G38116

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ of Md Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Caroline
(c) City or town Templeville
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Sitting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1888

8. AGE: Years	Months	Days	If less than one day
57 58	2	26	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Meredith
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Belle Chambers
15. Birthplace Maryland

16 (a) Informant Lillie Sitting
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/46 (month) (day) (year)
(c) Cemetery or crematory Templeville
Location Templeville, Md.

18 (a) Funeral director Raymond B. Rawlings
(b) Address Greensboro Md.

19 MAR 6 - 1946 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1946, at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1946 to March 5 1946, and that I last saw her alive on March 5 1946.

Immediate cause of death	Duration
Pneumonia, bilateral hypostatic.	3 weeks
Due to Lupus Erythematosus disseminatus, Acute	5 Mo
Due to	
Other Conditions Decubitus ulcers	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Osmund A. Wiesner
Address Univ. Hosp. Date signed 3/7/46

VS 150

X

G38117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Wust

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1874

8. AGE: Years	Months	Days	If less than one day
71	10	4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John P. Wust
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Wust
15. Birthplace Germany

16 (a) Informant Leonard J. Wust
(b) Address 1805 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7th 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Leo B. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Filed MAR 6 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th 1946, at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to March 5 1946 and that I last saw her alive on March 3 1946

Immediate cause of death Cardiac failure

Due to Arteriosclerotic cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Sborofsky M.D.
Address 601 N. Wolfe St Date signed 3/5/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

G38118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 Poplar Grove St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Graf.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 - 185[illegible]

8. AGE: Years 87 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Ludwig Schultz
13. Birthplace Germany.

MOTHER
14. Maiden Name Helene Schultz.
15. Birthplace Balto. Md.

16 (a) Informant Mrs Emma Stelb
(b) Address Silver Spring Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7 - 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Mem
Location Baltimore Md.

18 (a) Funeral director Jennie Cook Lyfer
(b) Address 1600 W. North Ave

19 (a) Received by (Registrar) MAR 6 - 1946 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4 1946, at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1945 to Mar 4 1946 and that I last saw h/W alive on Mar 4 1946.

Immediate cause of death: Stomach cancer

Duration: 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Grant T. Laine

Address 1726 Pop Gr St Date signed 3/6/46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G38119 ✓ G38119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Elkins Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Knight

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color of race	6 (a) Single, married, widowed, or divorced.
Male	White	~~Single~~ Married

6 (b) Name of husband or wife: Mary Knight nee Robinson
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 5 - 1870

8. AGE: Years	Months	Days	If less than one day
75	7 8	29	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Knight
13. Birthplace Balto

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto.

16 (a) Informant Mrs. Isabelle Knight
(b) Address 2626 Augusta Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave. Balto

19 (a) MAR 6 1946 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1946, at 10 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed 3-4-46

X

G38120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470

G38120 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Sarazen St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William John Schehlein
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Lorraine Schehlein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1891

8. AGE: Years	Months	Days	If less than one day
54	6	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Sparrows Point

FATHER
12. Name George Philip Schehlein
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Bauerschmidt
15. Birthplace Md.

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John F. Connelly
(b) Address Essex 21, Md.

19 (Date received by registrar) MAR 6 1946 (b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1946, to Mar 4 1946 and that I last saw h[e] alive on March 4 1946

Immediate cause of death Asphyxia

Due to Bronchopneumonia

Due to Bedridden Ca

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7 days
23 days
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent L. O'Shea M.D.
Address Maryland Ave. Date signed 3 Mar 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38121

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G38121

CERTIFICATE OF DEATH 182a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Doolittle Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eileen Marynancy Stritzinger

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 9 1946

8. AGE: Years | Months | Days 27 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Aloysius Stritzinger
13. Birthplace 1622 Doolittle Road

MOTHER
14. Maiden Name BARBARA VOSOLD
15. Birthplace BALTO.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Mar 6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lillyan Zeiler Inc.
(b) Address 403 S. Wolfe St. Hunting for Williams, Md.

19 (a) Filed by registrar Mar 6 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th 1946 19 ; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1946 to 3-5 1946 and that I last saw he alive on 3-5 1946

Immediate cause of death Asphyxiation due to head injuries — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Mesentric Lymphadenitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3-5-46 at 4:00 P.M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Street While at work? No
(Specify type of place)
(e) Means of injury Suffocation due to Bed Clothes

23. Signature M. D.
Address Date signed 3-6-46

VS 150 Medical Examiner Case) Released to Hospital 3/5/46 at 5:30 P.M
For S. Weld. Helfrich, by Thomas J. Curran, M. D.

correct age is especially important. Physicians: please write the

G38122

BALTIMORE CITY HEALTH DEPARTMENT

HB # 97788 CERTIFICATE OF DEATH 13B

Registered No. G38122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 12 yrs. 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1251 Knox Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theresa Anderson (nee Anderson) 6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1886

8. AGE: Years 60 | Months — | Days 13 | If less than one day hr. min.

9. Birthplace Md., Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George Anderson (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Malton
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8, 1946 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Balto., Md.

18 (a) Funeral director R. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) MAR 6 - 1946 (b) Received by (Registrar) Hampton Mills, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5, 1946 at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10, 1945 to Mar. 5, 1946 and that I last saw him alive on Mar. 5, 1946

Immediate cause of death: Pulmonary tuberculosis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis

Address B. C. H. Date signed 3/5/46

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G38123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42B

G38123 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 N. Belvedere Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 N. Belvedere Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sallie A. Fields

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William Fields

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9-1862

8. AGE: Years 83 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Rev. Nicholas Pearce
13. Birthplace Maryland

MOTHER
14. Maiden Name Lydia
15. Birthplace Maryland

16 (a) Informant Alan Fields, Jr.
(b) Address 1314 N. Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7-1946 (month) (day) (year)

(c) Cemetery or crematory Elmmaliza
Location Mt. Lady Mayor, Baltimore Co. Md.

18 (a) Funeral director Dudgee Funeral Home

(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 6 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7- 1946, at 10.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to March 4 1946. and that I last saw h[illegible] alive on March 4 1946

Immediate cause of death: Chronic Mitral Endocarditis — Duration: Unknown

Due to: Last Conflagration - Heart — 2 yrs +

Due to:

Other Conditions: Age

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Ensor M. D.

Address 7201 York Rd Date signed 3-6-46

X Phelps 12 Md

correct age is especially important... Physicians: please write the ... Every item of information should be carefully supplied. The ... the causes of death clearly and legibly.

G38124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 48

G38124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 E 23rd St
(c) Hospital or institution:
12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 E. 23rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara McKnight

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-5001

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Little Rock, Ark. (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Ely Sportswear 104 W Pratt

FATHER
12. Name John McGee
13. Birthplace Arkansas

MOTHER
14. Maiden Name Julia Parker
15. Birthplace Arkansas

16 (a) Informant Mrs. Clara Harrell
(b) Address 2321 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles [illegible] Williams
(b) Address 502 Madison Avenue

19 MAR 6 - 1946 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-46 19 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15, 1945 to 3-5- 1946, and that I last saw h[illegible] alive on 3-4-46 19

Immediate cause of death — Duration

Cancer of Uterus — 1 yr?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mamie Adams, M.D.
Address 312 E 23rd St Date signed 3-6-46

VS 3

X

G38125 BALTIMORE CITY HEALTH DEPARTMENT G38125

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Valley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Duffy
3 (b) If veteran, name war No
3 (c) Social Security Account No. No
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 80? Months Days If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name Peter Duffy
13. Birthplace Ireland
MOTHER 14. Maiden Name Mary McGowan
15. Birthplace Ireland
16 (a) Informant Mary E. Duffy
(b) Address 1007 Valley St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral Cemetery
Location 4300 Old Frederick Rd.
18 (a) Funeral director Edgar W. Coppelman & Son
(b) Address 644 E. Eager St.
19 (a) MAR 6 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 1946; at 4a M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1946 to 3/4 1946 and that I last saw him alive on 3/4 1946.

Immediate cause of death	Duration
Acute Bronchial Pneumonia	
Due to Chronic Cerebral Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. L. Thomas Lewis M. D.
Address 753 August Ave Date signed 3/6/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38126
J. L. -99624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38126

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR WRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Carlton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(over)

3 (a) FULL NAME Tony Denton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1903

8. AGE: Years	Months	Days	If less than one day
43	0	18	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Patrick V, 914 Balto. St.

FATHER
12. Name Francis Denton
13. Birthplace N. C.

MOTHER
14. Maiden Name Wilson
15. Birthplace N. C.

16 (a) Informant D. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 6 '46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) (b)

MAR 6 - 1946

Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946, to March 2 1946, and that I last saw him alive on March 2 1946.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathon Howland M. D.
Address B C H. Date signed 3/4/46

G38127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 D

G38127 Registered No.

Please write plainly with pen or typewriter. Be sure to answer every question. Be sure to report the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 m 3 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Allemarle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Warshuck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Peter Warshuck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
51 53	9	29		

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Karlsud
13. Birthplace Russia

MOTHER
14. Maiden Name Eva Burshut
15. Birthplace Russia

16 (a) Informant Peter L. Warshuck
(b) Address 2436 N. Charles St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof March 7 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Heydel & Kappel
(b) Address 315 S. Highland Ave

19 (a) Date received by registrar MAR 6 1946 Huntley W. Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946, at 7:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary sclerosis

Due to atherosclerosis

Other Conditions Fatty degeneration of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skaturelic M.D. Medical Examiner.
Date signed 3-4-46

940

G38128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G38128
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 N. Schroeder St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 N. Schroeder St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME: Vernon L. Williams

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1901

8. AGE: Years 45 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housepainter

11. Industry or business At home

FATHER
12. Name Hyland G. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Lightford
15. Birthplace Md.

16 (a) Informant Hyland G. Williams Father
(b) Address 1405 Hoblein Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director John M. Johnson
(b) Address 1700 Druid Hill Ave

19 (a) — (Date rec'd by registrar) MAY 6 1946 (b) Huntingdon Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946, to 3/2 1946, and that I last saw h.i.m. alive on 3/2 1946.

Immediate cause of death	Duration
Pulmonary embolism	
Due to phlebitis (rt saphinous vein)	3 days
Due to diabetes mellitus	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Brown M.D.
Address 1111 E. Madison Date signed 3/5/46

Raynor Brown M.D.

G38129 BALTIMORE CITY HEALTH DEPARTMENT G38129
CERTIFICATE OF DEATH 13 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2416 Banger St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Banger St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles P. Lamanna Sr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Marie J. Gayeski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1876

8. AGE: Years	Months	Days	If less than one day
69	4	19	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Augustin
13. Birthplace Italy

MOTHER
14. Maiden Name Not Known
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 2416 Banger St.

17 (a) Burial (b) Date thereof 3/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (b) Hamilton Williams M.D.
(Date rec'd by registrar)

MAR 6 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946, at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to March 3 1946, and that I last saw h[illegible] alive on March 2 1946

Immediate cause of death Pulmonary Edema — Duration

Due to Left Ventricular Dilatation Acute Myocardial Infarction

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Hamilton C. Williams
Address 2457 W. Lexington Date signed 3/5/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] of information should be carefully supplied. The

G38130 BALTIMORE CITY HEALTH DEPARTMENT G38130

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3921 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna N. Connors

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1866

8. AGE: Years 80 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name not known
13. Birthplace Ireland

MOTHER
14. Maiden Name not known
15. Birthplace Ireland

16 (a) Informant Mrs. Helen Wolf
(b) Address 3921 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) Mar 6 1946 registrar [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946, at 8:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1946 to March 3 1946, and that I last saw h.. alive on March 3 1946.

	Duration
Immediate cause of death: Myocardial Failure	30 hrs.
Due to: Arteriosclerotic Heart	10 yrs.
Due to: Generalized Arteriosclerosis	15 yrs.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clayton W. LeGrand M. D.
Address 601 S. Ellwood Ave. Date signed 4 Mar 46

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly. The return of information should be carefully supplied. The

G38131 ✓ G38131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

Please write the causes of death clearly and legibly. The accuracy is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Mt Holly
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Nicholas Richwein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Regina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26 1868

8. AGE: Years 77 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Furniture manufacturing

FATHER
12. Name John
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Regina Richwein
(b) Address 516 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A Sitzler
(b) Address 4101 Edmondson Ave

6 (a) 1946 Registered by Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/1946 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21/1946 to 3/4/1946 and that I last saw him alive on 3/4/1946

Immediate cause of death	Duration
CA. Stomach Metastasis to Liver	
Due to	
Due to Post operative Gastro Enterostomy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/26/46

Major findings of operation: CA. Pyloric End of Stomach

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Norton Jr M.D.

Address Bon Secours Hosp. Date signed 3/11/46

G38132

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38132

CERTIFICATE OF DEATH 46E

Registered No.

Correct age is especially important. Physicians: please write the information should be carefully supplied. The the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1318 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary A. Shaunahan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late James M. Shanahan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1870.

8. AGE: Years 75 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Patrick Spearman
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace Ireland

16 (a) Informant Mrs. John Burns (Daughter)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry H. Tuttle
(b) Address 4101 E. Monument Ave.

19 (a) 3/6 1946 (Date received by registrar) (b) Registrar
Huntington Milliard, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946 at 8:40 P.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1946 to 3/3 1946 and that I last saw h[illegible] alive on 3/3 1946

Immediate cause of death: C A - O Ecum — Duration: 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/10/46

Major findings of operation: adeno CA - Ocum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address St. Agnes, Bo. Date signed 3/3/46

G38133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G38133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Dry Dock Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 S. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Wilhelm

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1924

8. AGE: Years 22 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business Md. Dry Dock Co.

FATHER
12. Name Harry E. Wilhelm
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Balto. Md

16 (a) Informant Mrs. Mary Wilhelm
(b) Address 41 S. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 . 8 . 46 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location 55-01 Frederick Rd.

18 (a) Funeral director Harry R. Withe
(b) Address 4101 Edmondson Ave.

19 (a) [illegible] Huntington Williams

MAR 6 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 05, 1946 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
* Drowning
Skull fracture
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-5-46 2:30 P.M.
(b) Where did injury occur? Md. Dry dock
(c) Did injury occur at home, on farm, industrial place, in public place? Work Ind. While at work? Yes
(d) Means of injury Fell overboard

23. Signature Benedict Stitarelis M.D.
Medical Examiner.
Date signed 3-5-46

X

G38134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G38134

1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S Lapsit St
(c) Hospital or institution Balto. Gen. Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Annunciata Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl William Bardens Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 5 hr. 30 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl W. Bardens
13. Birthplace Amsterdam N.Y.

MOTHER
14. Maiden Name Mary V. Smith
15. Birthplace Balto. Md.

16 (a) Informant Father
(b) Address 1436 Annunciata Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 6 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 MAR 6 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-46 1946, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6-46 19 to 19, and that I last saw h.i.m. alive on 3-6-46 19

Immediate cause of death: Pneumonia

Due to (ant. 3 hrs. - 5 min.)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harold Williams Jr. M.D.
Address L.B.C.H. Date signed 3-6-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G38135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G38135 Registered No.

Type or print plainly in ink. Physicians: please write the cause of death clearly and legibly. Where age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3680 Ash Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Goochland
(c) City or town Rural Payne
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Biddle James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife Sadie James

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1873

8. AGE: Years 72 | Months 3 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Burlington, New Jersey (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Farm

FATHER 12. Name Richard James

13. Birthplace New Jersey

MOTHER 14. Maiden Name Susanna McClure

15. Birthplace New Jersey

16 (a) Informant William James

(b) Address 3680 Ash St Baltimore, Md.

17 (a) Burial (b) Date thereof March 8, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Near Payne, Va.

Location Upton Goochland County

18 (a) Funeral director Johnson Funeral Home

(b) Address Depot Grove, Va.

19 (a) 6 Mar 1946 Huntington Williams, Mgr
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1946, to March 6 1946, and that I last saw h.i.m. alive on March 6 1946.

Immediate cause of death	Duration
Carcinomatosis —	?
Ca of Stomach	
Due to	
Due to	
Other Conditions Arteriosclerotic VD	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Shumaker M. D.

Address 3711 Dalls Rd Date signed 3-6-46

G38136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

G38136

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University
(c) Hospital or institution:
University Hosp D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Addison St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Walter T. Craver

3 (b) If veteran, name war: None
3 (c) Social Security Account No. .....

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Molly Marie Craver
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23, 1902

8. AGE: Years 43 (43) | Months 9 | Days 11 14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business B & O. R.R.

FATHER
12. Name Zachariah Craver
13. Birthplace Virginia

MOTHER
14. Maiden Name Lena Zohn
15. Birthplace Germany

16 (a) Informant Molly Marie Craver
(b) Address 122 S. Addison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) Filed by registrar MAR 7 1946 (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 3 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed chest
Fractured pelvis
Due to .....
.....
Other Conditions .....
.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-6-46 at 11/2 50 A.M.
(b) Where did injury occur? B & O RR. Mt. Royal
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury probably stipple by train

23. Signature Benedict Skiotarelis M.D.
Medical Examiner.
Date signed 3-6-46.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The city, town or information should be carefully supplied.

638137 AB-99088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 638137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3522 Dupont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Albert King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15- 1869

8. AGE: Years	Months	Days	If less than one day
76	9	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph A. King (D)
13. Birthplace England

MOTHER
14. Maiden Name Mary MacMiry
15. Birthplace England

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/9/46 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Balto.
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) ~~(Signature of~~ (b) ~~registrar)~~ Huntington Williams M.D.

MAR 9 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6- 1946, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6- 1946 to 3-6- 1946 and that I last saw h- alive on 3-6- 1946

Immediate cause of death	Duration
Pulmonary edema	1 day
Due to Coronary thrombosis	3 yrs.
Due to Diabetes mellitus	yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: no autopsy

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Baltimore Hospitals Date signed 3-9-46

X

638138 | BALTIMORE CITY HEALTH DEPARTMENT | 638138

CERTIFICATE OF DEATH 46F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 344 S Robinson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 344 S Robinson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M Cortina

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ervin L Cortina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 1905

8. AGE: Years	Months	Days	If less than one day
40	6	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk Supervisor
11. Industry or business Thermal Drug

FATHER
12. Name Frederick Mack
13. Birthplace Germany

MOTHER
14. Maiden Name Walpurga Gist
15. Birthplace Germany

16 (a) Informant Ervin L Cortina
(b) Address 344 S Robinson St

17 (a) Cremation (b) Date thereof 3/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grun Mount
Location Baltimore Md

18 (a) Funeral director Wilkens Funeral Dir
(b) Address 1217 E Cold St

MAR 7 - 1946 (b)
(Date rec'd by registrar)

Filed by Wilkens M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946 at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1945 to 3/4 1946
and that I last saw h[illegible] alive on 3/4 1946

Immediate cause of death Carcinoma of the Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Atkins
Address 3211 Eastern Ave Date signed 3/6/46

VS 150

X

correct age is especially important. Physicians: please write the

G38139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G38139 Registered No. 16

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2253 Eddey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2253 Eddey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Parks Payne

3 (b) If veteran, name war No

3 (c) Social Security Account No. 217-18-6436

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mabel M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1889

8. AGE: Years 56 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Glyndon Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Charles Payne
13. Birthplace Md

MOTHER 14. Maiden Name Mary A Kellum
15. Birthplace Ga.

16 (a) Informant Paul Lowry
(b) Address 2361 Eddey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/46 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md

18 (a) Funeral director Wilson & Johnson
(b) Address 1317 N Gay St

Date received by local registrar MAR 7 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to March 6 1946 and that I last saw h[illegible] alive on March 6 1946

Immediate cause of death Coronary Thrombosis — Duration 2 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 301 Arlington Ave Date signed 3/6/46

VS 150

X

G38140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G38140

Please write the causes of death clearly and legibly. Physicians: please write in all cases where age is especially important. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1542 N. Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTHER MILLMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife HARRY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name OSHER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name EVA
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-7-46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location GERMAN HILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.

MAR 7 - 1946 (Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1946, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1946 to 3/5 1946. and that I last saw her alive on 3/5 1946

Immediate cause of death: Carcinoma of Colon and rectum — Duration

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Schaeffer M.D.
Address 2225 Linden Ave Date signed 3/6/46

VS 150

G38141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G38141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 Riggs ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Maltz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Mary Olivia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22. 1869

8. AGE: Years	Months	Days	If less than one day
81	7	13	hr. min.

9. Birthplace Baltimore
(Town, county and state)
10. Usual Occupation Waiter, Dom'stic
11. Industry or business "

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Ella L. Osborn
(b) Address 2804 Riggs ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 3/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Lafayette Div W 56

18 (a) Funeral director John D. Mitchell Son
(b) Address 1116 Eutaw Place
(c) (Date received by Registrar) MAR 7 - 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-1946, at 9:55 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular & Confluent lobular pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 1811
(a) Date of injury at 2-27-46 M.
(b) Where did injury occur? Fremont & Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Fraser M.D.
Medical Examiner.
Date signed 3-6-46

VS 151

G38142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G38142

Please write the causes of death clearly and legibly. Typewriting necessary supplies. Physicians: please write the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Wis. (b) County.....
(c) City or town Madison
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Lincoln Pl.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Carol Dean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-16-37

8. AGE: Years: 8 | Months: 3 | Days: 20 | If less than one day: ..... hr. ..... min.

9. Birthplace Wis.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Norman Dean
13. Birthplace Canada

MOTHER
14. Maiden Name Ruth Baker
15. Birthplace Ind.

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9 46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell Son
(b) Address 901 Eastern Pkwy

19 (a) MAR 7 1946 (Date rec'd by registrar) Hamilton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 1946 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1946, to Mar 6 1946 and that I last saw h.r Alive on Mar 6 1946.

Immediate cause of death Cardiac Failure — Duration 5 minutes

Due to Ventricular Fibrillation — 8 yrs.

Due to Pulmonary Stenosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-6-46

Major findings of operation: Pulmonary Stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature J. Meyers M.D.
Address Johns Hopkins Hosp. Date signed 3-6-46

VS 150

G38143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

G38143

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Inverness Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Woodland Dr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ora McCartney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married,~~ widowed, or ~~divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 26 82

8. AGE: Years 63 Months 3 Days 9 If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lee Burrows
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah Wright
15. Birthplace West Virginia

16 (a) Informant Ernest McCartney
(b) Address 2928 Yorkaway, Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9 1946 (month) (day) (year)

(c) Cemetery or crematory Meadow ridge
Location Baltimore, Md

18 (a) Funeral director Kenwood L. Corrington
(b) Address 21 W. 25th St.

19 (a) (b) Registrar

MAR 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1946 to March 5 1946, and that I last saw her alive on Mar. 5 1946.

Immediate cause of death	Duration
Pulmonary Embolus.	
Due to Thrombophlebitis of right Femoral Vein.	
Due to	
Other Conditions Carcinoma - uterus Paroxysmal Auricular tachycardia (Include pregnancy within 3 months of death)	

Date of operation Feb 23, 1946

Major findings of operation: Carcinoma - Fundus

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick W. Lertrand, M.D.

Address St Josephs Hosp Baltimore Date signed 3/5/46

Hamilton Hillsville, M.D.

100 B

G38144

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G38144

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6910 Copeleigh Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Faye E. Graham 243697

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOHN A. GRAHAM
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) AUG. 25-1909

8. AGE: Years	Months	Days	If less than one day
36	6	11	hr. min.

9. Birthplace DEAL'S ISLAND MD
(Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name PERRY F. WHITE
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ANNIE PARKINSON
15. Birthplace MARYLAND

16 (a) Informant JOHN A. GRAHAM
(b) Address 6910 COPELEIGH ROAD

17 (a) REMOVAL (b) Date thereof MARCH 7-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOWER CHURCH CEM
Location Deal's Island, Md.

18 (a) Funeral director Chas E. Cranmer Son
(b) Address 118 W. Mt Royal Ave

19 MAR 7 - 1946 (b) [illegible] Millsboro, Md.
(Date received by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1946 at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946 to 3-6 1946 and that I last saw her alive on 3-6 1946

Immediate cause of death — Duration

Respiratory Failure

Due to Pulmonary Tuberculosis

Due to

Other Conditions Pregnancy — Miscarriage about 20 weeks

(Include pregnancy within 3 months of death)

Date of operation before death

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M E Roberson M. D.
Address St Joseph Hosp. Date signed 3-6-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Recd. 3/13/46

638145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

R 638145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 W. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Herold

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 15 - 1880

8. AGE: Years	Months	Days	If less than one day
66	—	20	hr. min.

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)

10. Usual Occupation RETIRED WATCHMAN

11. Industry or business GOVERNMENT

FATHER
12. Name GEORGE M. HEROLD
13. Birthplace MARYLAND

MOTHER
14. Maiden Name FANNIE MURDOCH
15. Birthplace MARYLAND

16 (a) Informant MRS. DOROTHY KENNARD
(b) Address 1722 E. 31ST ST.

17 (a) BURIAL (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Evans & Sons
(b) Address 118 N. Mt. Royal Ave

19 (a) (Date received by registrar) MAR 7 - 1946 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 5 - 1946 at 10:45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bronchiogenic Carcinoma

Due to: of lung with

Mets to adr.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wilkens M.D.
Medical Examiner.
Dated 3-5-46

G38146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8.3a

G38146 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1145 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Isaiah Wade

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	26	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Oscar F. Jackson
(b) Address 1145 Fulton ave

17 (a) Burial (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. U. Kelson
(b) Address 1303 Pleasantman Ln

19 (a) (Date received by Registrar) MAR 7 1946 (b) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1946, at 8 15 A. M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

D. Signature Robert Lee Graham M.D.
Medical Examiner.
Signed 3-6-46

313866
G38147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V13B

G38147
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 E Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Sutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-'18

8. AGE: Years 28 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace N. Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Sutton
13. Birthplace N. C.

MOTHER
14. Maiden Name Viola Cook
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Rocky Mt. N.C.
Location Rocky Mt. N.C.

18 (a) Funeral director Lee A. G. Nelson
(b) Address 1213 Pennsylvania Ave

19 (a) MAR 7 - (Date rec'd by registrar) (b) 1946 Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1946 to Mar. 3 1946 and that I last saw him alive on Mar. 3 1946.

Immediate cause of death	Duration
Miliary Tuberculosis	?
generalized - for aforesaid	
Due to	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dr. Oehme

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Williams M. D.
Address Johns Hopkins Hosp Date signed 3-4-46

VS 150

Please answer all questions as expertly important. Physicians: please write the causes of death clearly and legibly.

G38148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G38148

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ELMHURST NURSING HOME
(c) Hospital or institution: 1708 EUTAW PLACE 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 S. MACON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT FEIBER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LOUISA FEIBER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 6 1862

8. AGE: Years	Months	Days	If less than one day
83	5 6	0	hr. min.

9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business BREWERY

FATHER
12. Name FRANZ FEIBER
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name FRANCISCA ?
15. Birthplace AUSTRIA

16 (a) Informant IDA PATTEN (DAUGHTER)
(b) Address 306 S. MACON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 8/46 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 MAR 7 - 1946 (Date rec'd by [illegible])

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 6 1946 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Feb 1946 and that I last saw him alive on Feb 4 1946.

Immediate cause of death	Duration
Pulmonary Thrombosis Pulmonary Embolism	2 yrs.
Due to Acute Myocardial Insufficiency	1 mo.
Due to Senile Marasmus	
Other Conditions Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. G. Geyer M. D.
Address 1564 Madison Ave Date signed 3/7/46

VS 150

Wm. G. Geyer 3/7/46

G38149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Ritterpusch

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry Ritterpusch
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1883

8. AGE: Years 53 | Months 1 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name Daniel Rau
13. Birthplace Baltimore

MOTHER 14. Maiden Name Barbara Petroff
15. Birthplace Bavaria

16 (a) Informant Harry Ritterpusch
(b) Address 218 Ellwood Ave

17 (a) Burial (b) Date thereof March 8
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (b)

MAR 7 1946 Registrar

Hunting for Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1946, at 6:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/0 1946, to 3/5 1946, and that I last saw her alive on 3/5 1946

Immediate cause of death	Duration
Congestive heart failure	4 days
Due to Chronic Myocarditis	—
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. Schubert Jr.
Address Bon Secours Hosp Date signed 3/5/46

X

Physicians: please write the causes of death clearly and legibly.

638150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

638150
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information requested hereon should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden + Madeira Ave

(c) Hospital or institution Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2716 Woodsdale
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances E Nice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James A Nice

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Oct 30 /22

8. AGE: Years 23 | Months 4 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Edgar Chaplain

13. Birthplace Md

MOTHER 14. Maiden Name Lula Evans

15. Birthplace Md

16 (a) Informant James A Nice

(b) Address 2716 Woodsdale

17 (a) Burial (b) Date thereof Mar 9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto Co Md

18 (a) Funeral director Uhlmeyer Funeral Home

(b) Address 2018 Orleans

19 (a) (b)
(Date received by registrar) Registrar

MAR 7 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/ 1946, at 8 58 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/ 1946 to 3/6/ 1946, and that I last saw her alive on 3/6/ 1946

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary edema

Due to Bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C C Gonzalez

Address Maryland General Hospital Date signed 3/6/46

Hunter H. Williams, M.D.

C C Gonzalez

G38151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G38151

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4900 Roland Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4900 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Franklin Baetjer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Catherine Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1859

8. AGE: Years 86 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Dry goods

FATHER
12. Name
13. Birthplace Unk.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Miss Ruth Baetjer
(b) Address 4900 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/46 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

(Date received by Registrar) MAR 7 - 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Mar 6 1946, and that I last saw him alive on Mar 6 1946

Immediate cause of death: Intestinal Obstruction — Duration

Due to Carcinoma

Transverse Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hester A Baetjer M. D.

Address 1115 St. Paul St. Date signed

Please answer all questions as especially important. Physicians: please write the causes of death clearly and legibly.

G38152 HB 99735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38152 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6308 Hamilton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Koerber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles F. Koerber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1891

8. AGE: Years	Months	Days	If less than one day
54	9	22	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Dimpert
13. Birthplace Germany

MOTHER
14. Maiden Name Christina?
15. Birthplace Germany

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore
18 (a) Funeral director Leonard D. Ruck
(b) Address 5305 Harford Rd.
19 (a) MAR 7 1946 (b)
(Date received) (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6, 1946, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6 1946 to Mar. 6, 1946 and that I last saw h. er alive on Mar. 6, 1946

Immediate cause of death: cerebrovascular accident — Duration
Due to: arteriosclerosis
Due to:
Other Conditions: Hypertension cardiovascular disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jonathan Howland M. D.
Address B. C. H. Date signed 3/6/46

83a

Please write clearly in ink. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G38153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38153 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 Springdale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Springdale Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Robert Williams Fitchett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Y. Fitchett
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 12/28/1883

8. AGE: Years	Months	Days	If less than one day
62	2	8	....hr. ....min.

9. Birthplace Portsmouth, Va. (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Navy Yard

FATHER
12. Name Lorian Devorax Fitchette
13. Birthplace Portsmouth, Va.

MOTHER
14. Maiden Name Martha Williams
15. Birthplace Portsmouth, Virginia

16 (a) Informant Emma Young Fitchette
(b) Address 206 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Olive Branch
Location Portsmouth, Va

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Hghts. Ave.

MAR 7 1946 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1946, at 11 P.M

21. I certify that I took charge of the remains described above, held an Autopsy & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Les death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death).

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....at .... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratton M.D. Medical Examiner.
Date signed 3-6-46

VS 151

G38154 BALTIMORE CITY HEALTH DEPARTMENT G38154

CERTIFICATE OF DEATH 46 B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please fill out all items. Use ditto marks only when they will not be misunderstood. Do not abbreviate. Write with ink. Space left for any entry supplied. The exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway 6
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 61
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida B. Blake

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Austin B. Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	27	hr. min.

9. Birthplace Md. Anne Arundel County (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles C Brice
13. Birthplace Md Anne Arundel Co.

MOTHER
14. Maiden Name Justina Springer
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address Mr. Walter C. Tilghman 5730 6th St., Arlington, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 1003 E. Baltimore St.

19 MAR 7 1946 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-1946, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-45 to 3-6-1946 and that I last saw him alive on 3-6-1946

Immediate cause of death	Duration
Cerebral Vascular accident	
Due to Arteriosclerotic - Hypertension	
Due to	
Other Conditions Gastritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Mural thrombus, heart
of autopsy Left Colon and rectum to abdominal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Hinkley M. D.
Address Church Home & Hosp. Date signed 3-7-46

Hunting for Nicaea, Md

638155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 638155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1139 N. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 N Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Jordan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1881

8. AGE: Years 64 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace N.C.

MOTHER
14. Maiden Name Bessie Henderson
15. Birthplace N.C.

16 (a) Informant Mrs. William Jordan.
(b) Address 1521 N. Lexington St.

17 (a) Shipped (burial, cremation, or removal) (b) Date thereof March 10, 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Henderson, N.C.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.

19 (a) This certificate received MAR 8 1946 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 1946, at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2-1946 to 3-4 1946, and that I last saw h[illegible] alive on 8/3 1945.

Immediate cause of death	Duration
Diabetes Mellitus	2
Due to	Mo
Due to	1
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Peterson M. D.
Address 1525 Eutaw Pl Date signed 3/9/46

X

G38156 G38156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Edmondson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 N. Eaton St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Adolf N. Hecht

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Johanna Lenz

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1859

8. AGE: Years	Months	Days	If less than one day
87	0	29	..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Accountant

FATHER
12. Name Henry C. Hecht
13. Birthplace Unknown

MOTHER
14. Maiden Name Marie (Unknown)
15. Birthplace Unknown

16 (a) Informant Lizetta Falck
(b) Address 3055 Spaulding Ave

17 (a) Burial (b) Date thereof 3/9/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

MAR 8 - 1946 Hugh [illegible] Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1946 at 4:20 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
1. Arteriosclerotic CVD
Patient

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature R. M. Falck M.D.
Medical Examiner.
Date signed 3/7/46

VS 151

G38157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

G38157 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 W. Fayette ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin Barker

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-7882

4. Sex: M | 5. Color or race: W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Margaret L. Barker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/1868

8. AGE: Years 77 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Retired Telegraph Operator

11. Industry or business Pa. R. R.

FATHER
12. Name Alexander Barker
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Marvin R. Barker
(b) Address 405 Whitridge Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

MAR 8 - 1946 (Date received by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquestion thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☐; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Mouth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 7 1946

X

G38158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. G38158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8211 Long Point Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John La Plante

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-46

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph La Plante
13. Birthplace Worcester Mass.

MOTHER
14. Maiden Name Nellie Edwina Johnston
15. Birthplace Cornwall Pa.

16 (a) Informant Joseph La Plante
(b) Address 8211 Long Point, Rundale

17 (a) Burial (b) Date thereof 3/8/46 (month) (day) (year)
(Burial, ~~cremation~~, or removal)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 8-1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 March 1946, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1946 to 3-7 1946, and that I last saw him alive on 3-7 1946

Immediate cause of death	Duration
Complete atelectasis, bilateral.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence W Martin M. D.
Address 1400 N Caroline St Date signed 3-7-46

VS 150

X

Physicians: please write the causes of death clearly and legibly. Entries are especially important.

G38159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G38159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Pine. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town (If outside city or town limits, write RURAL and give town) 425N. Pine. St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA JOHNSON.

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex Female. 5. Color or race Col. 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife GEORGE.
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) IO. 5. 189I.

8. AGE: Years 54 5I | Months 6 | Days I | If less than one day ..... hr. ..... min.

9. Birthplace Essex. County. Va. (Town, county, and state)

10. Usual Occupation House. Wife.

11. Industry or business

FATHER
12. Name James Wheeler.
13. Birthplace Virginia.

MOTHER
14. Maiden Name Lucy Jones.
15. Birthplace Virginia.

16 (a) Informant George Johnson.
(b) Address 425. Pine. St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 3. 9. 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn. Cem.
Location Baltimore. Md.

18 (a) Funeral director William A Jackson.
(b) Address 916. Penna. Ave.

MAR 8 - 1946 (Date rec'd by Local Registrar) (b) Huntington Millington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6. 1946 9PM. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 4 1946 to Mar 6 1946 and that I last saw h[illegible] alive Mar 6 1946

Immediate cause of death: Coronary Thrombosis — Duration 2 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature [signature] M. D.
Address 753 [illegible] Date signed 3-7-46

VS 150

Please answer all questions as completely as possible. Use ink. Physicians: please write the cause of death clearly and legibly.

638160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

Registered No. 638160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell Speard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-20-16

8. AGE: Years	Months	Days	If less than one day
29	10	15	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Gardener
11. Industry or business

FATHER
12. Name Willie Speard
13. Birthplace S. C.

MOTHER
14. Maiden Name Alice Williams
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd) (b) Registrar

MAR 8 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Mar 5 1946, and that I last saw h[illegible]live on Mar 5 1946.

Immediate cause of death	Duration
Respiratory obstruction	
Due to Aneurysm of aorta	
Due to tertiary syphilis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Johns Hopkins Hosp.
Address Johns Hopkins Hosp. Date signed 3/5/46

X

Physicians: please write the causes of death clearly and legibly. Cause of death is especially important.

Dr. Sawyer
4808 Harford Road

G38161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G38161

Write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the information required. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2921 Shirey Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Beltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Richard Funk

3 (b) If veteran, name war	3 (c) Social Security Account No. 214-14-3291

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	8	hr. min.

9. Birthplace Hagerstown, Maryland
(Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business State Roads Com.

FATHER
12. Name Edward Funk
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Mary K. Snyder
15. Birthplace Hagerstown, Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/46 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagertown, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

19 (a) (b) Date signed MAR 8 1946 Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1946 at 2-30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945 to Mar. 8 1946 and that I last saw h[illegible] alive on Mar 7 1946.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to Coronary Heart Disease	1 year
Due to arteriosclerotic Heart Disease	4 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury George Sawyer M.D.
23. Signature 4808 Harford Rd.
Address Balto. Md. Date signed 3/8/46

X

638162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

638162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1769 Carswell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1769 Carswell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen E. Mettee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Merrick C.
6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31-1851

8. AGE: Years	Months	Days	If less than one day
94	2	6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Isaac Gardiner
13. Birthplace Balto.

MOTHER
14. Maiden Name Julia A. Miller
15. Birthplace Balto.

16 (a) Informant Miss Mettee
(b) Address 1769 Carswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Fuchs
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 8 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1945 to Mar 6 1946 and that I last saw h[illegible] alive on Mar 5 1946.

Immediate cause of death	Duration
Senile Bronchitis	5 mo
Due to Infirmity Old age	
Due to Chronic Heart dis	?

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E N Meyer Jr
Address 1520 E 33rd St Date signed 3/7/46
M. D.

X

correct age is especially important. Physicians: please write the

G38163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G38163 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 S. Chester Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARION WALSTRUM

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Peter J. Walstrum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 8, 1869

8. AGE: Years 75 | Months 7 | Days 0 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Lewis
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary Simpson
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. Harry Wood
(b) Address: 1704 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1946 at 2.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to March 6 1946 and that I last saw her alive on March 6 1946.

Immediate cause of death	Duration
(a) Uremia - Cardio-Vascular degeneration	Uremia
Due to (b) Chr. Hypertension & Chr. Arterio Sclerosis	5 yrs
Due to (c)	
Other Conditions: Coronary Thrombosis	14 m.

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1001 E. Fayette Date signed 3/8/46

Huntington Millinnes, M.D.

G38164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G38164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 n. Patterson Pk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENIA ELIZABETH LENNAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Alvin Sawyer Lennan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1854

8. AGE: Years 91 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Brooks
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ellen Booze
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Lida N. Powell -daug
(b) Address 718 N. Patterson Pk. Ave.

17 (a) Burial (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 7.50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to March 6 1946 and that I last saw her alive on March 6 1946.

	Duration
Immediate cause of death: ARTERIOSCLEROSIS	10 YRS
Due to HYPERTENSION	5 YRS
Due to	
Other Conditions UREMIA	7 DAYS

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Kavanaugh M.D.
Address 3328 McElderry Date signed 3-7-46 M. D.

X

Please answer all questions as especially important. Physicians: please write the causes of death clearly and legibly.

G38165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. Waterloo Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Coar

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1974

8. AGE: Years	Months	Days	If less than one day
71	6	6	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Unemployed Retired
11. Industry or business

FATHER
12. Name Isaiah Coar
13. Birthplace Pa

MOTHER
14. Maiden Name Amanda Gray
15. Birthplace Md

16 (a) Informant Mrs Mary A Coar
(b) Address Ellicott City Md

17 (a) Burial (b) Date thereof 3-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Paul
Location Sutton Md.

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

MAR 9 1946

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1946, at 7:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1946 to 3/6 1946 and that I last saw he/she alive on 3/6 1946.

Immediate cause of death Septicemia — Duration
Due to Acute Bacterial Endocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of autopsy Multiple Infarcts Vegetative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Reindollar Jr. M.D.
Address St Agnes Hosp Date signed 3/6/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G38166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G38166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 Spaulding ave.
(c) Hospital or institution:
27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Spaulding Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Hammerslough

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Myrtle D. Hammerslough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1875

8. AGE: Years	Months	Days	If less than one day
71	2	6	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Union Memorial Hosp.

FATHER
12. Name Julian Hammerslough
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Cecilia Meyers
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Myrtle D. Hammerslough
(b) Address 3606 Spaulding Ave.

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd MAR 8 - 1946 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7- 1946, at 7 30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-7-46

G38167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G38167 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Lowell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Haley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 8 1946 (Date rec'd by registrar) (Signature of Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-1946, at 2 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-18-46 at 2 P. M.
(b) Where did injury occur? 813 Lowell St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Stabbed

23. Signature Benedict Shatarsky M.D. Medical Examiner.
Date signed 2-19-46

3336

G38168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G38168

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Forrest St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME James L. Smith

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
45			..... hr. ..... min.

9. Birthplace .....
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 MAR 8 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-1946, at 9 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of neck and chest

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-20-46 E. 25 P. M.
(b) Where did injury occur? 8 N. Dallas St.
(c) Did injury occur at home, on farm, industrial place, in public place? Friend's home While at work? No.
(d) Means of injury Stabbed during altercation

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 2-21-46

F 3837

G38169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G38169
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4221 Curtis Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Curtis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 7 1946
Commissioner of Health

18 (a) Funeral director
(b) Address

19 MAR 8 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 15f

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946, at 10:10 A

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular - renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 2-25-46

F 8338

638170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 638170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 631 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Farron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School MAR 7 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 8 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Feby 1946, at 5.15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Nelson M.D.
Medical Examiner
Date signed 22 Feby 46

F 5839

X

G38171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G38171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 N. Mount St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 N. Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Carrie Crump

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Crump
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 4, 1905
8. AGE: Years 40 | Months 8 | Days — | If less than one day — hr. — min.
9. Birthplace Winnsboro S. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Thomas Ashford
13. Birthplace Winnsboro S. C.

MOTHER
14. Maiden Name Carrie Ashford
15. Birthplace Winnsboro, S. C.

16 (a) Informant John Crump Husband
(b) Address 537 N. Mount St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location ____
18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.
19 (a) ____ (b) ____

MAR 8 1946
VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 5:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1946, to 3/4 1946, and that I last saw her alive on 3/4 1946.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to Bacteria Infection	
Due to	
Other Conditions Myocardial failure (Include pregnancy within 3 months of death)	

Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____
23. Signature Franklin Phillips M. D.
Address 1543 Penn. Ave Date signed 3/6/46

G38172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Registered No. G38172

The items on this certificate must be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 D. Hanover St.
(c) Hospital or institution: 23

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 D. Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wm. Schneider

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Katherine Schneider
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1899

8. AGE: Years	Months	Days	If less than one day
46	2	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Farmers Proprietor
11. Industry or business

FATHER
12. Name Mat Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Arnold
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Katherine Schneider
(b) Address 1301 D. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Patapsco Highway

18 (a) Funeral director Chas. F. Sumwalt Co.
(b) Address 1216 D. Charles St.

19 MAR 8 - 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/19 46 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from December 45 to 3/6 19 46
and that I last saw h... alive on 3/6 19 46

Immediate cause of death aspergillosis — Duration 5 mos

Due to Reputed culture at State Health Dept — Duration —

Due to posture pr. asphyxia — Duration —

Other Conditions Acute cardiac failure c. pulmonary oedema — Duration 2 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller
Address 1216 D. Charles St Date signed 3/11/46

G38173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G38173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 29.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S Warwick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Reany.

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	✓

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-2-46 1 day

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name Harvey Edward Reany.
	13. Birthplace Baltimore, Md.
MOTHER	14. Maiden Name Dorothy E. Horstman
	15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Ed. Reany
(b) Address 1900 Spruce St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Frederick Ave
18 (a) Funeral director Riggins Funeral Home
(b) Address 216 N. Charles St.
19 (a) Mar 8 1946 (Date received by registrar) (b) Registry No.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-46 1946, at 9 A. M. 15

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2-46 1946 to 3-7- 1946, and that I last saw her alive on 3-7 1946

Immediate cause of death	Duration
Intra cranial hemorrhage	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Mitchell Jr. M. D.
Address Bon Secours Hosp. Date signed 3/7/46.

X

G38174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2868 Kentucky ave.
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2868 Kentucky Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Vogt

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife John Vogt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) December 1-1869
8. AGE: Years 76 | Months 3 | Days 5 | If less than one day hr. min.
9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Albert Koenig
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Andrew Danzer
(b) Address 2868 Kentucky ave.
17 (a) Burial (b) Date thereof 3-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto
18 (a) Funeral director Jos J Gerst & Son
(b) Address 2801 Kentucky ave
(b) Huntington Millington, MD
MAR 8 - 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 11 am M
21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1946, to March 6 1946, and that I last saw h-r alive on March 5 1946

Immediate cause of death	Duration
Broncho Pneumonia	2d.
Cerebral Hemorrhage	5d.
Due to Mitral Stenosis	6 mos
Hypertension	6 mos
Due to Chronic Interstitial Nephritis	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T. F. A Stevens M. D.
Address 2878 Harford Av Date signed 3-7-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38175 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G38175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 61
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Whittington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 3 | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 8 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17th 1946, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Diaphragmatic Hernia
Intestinal obstruction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shetaruette M.D.
Medical Examiner.
Date signed 3-18-46

5340

638176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

638176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Burrows Way
(If rural give location)
(e) Citizen of foreign country? Born Wal (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 6 hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc. Johns Hopkins Medical School MAR 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 8 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946 at 4:28 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis of lungs, bilateral

Due to

Other Conditions

(Include pregnancy within 3 months of death).

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarlic M.D.
Medical Examiner.
Date signed 3-1-46

5341

G38177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G38177

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: St Josephs Hospital 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) mos. 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Herbert Hickman ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/45

8. AGE: Years | Months: 3 | Days: 15 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry W. Hickman
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Emma C. Brooks
15. Birthplace Baltimore Md

16 (a) Informant Mrs Henry Hickman
(b) Address 931 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Taylor Ave

18 (a) Funeral director Leo G. Leacock
(b) Address 1701-03 N. Patterson Park Ave

19 (a) MAR 8 - 1946 (b) Huntington Williams Registrar
Received by Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1946, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1946 to 3/7 1946, and that I last saw him alive on 3/7 1946.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Broncho-pneumonia

Due to Acute Laryngo-Tracheo-Bronchitis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Frank J. Ayd Jr
Address St Joseph Hospital Date signed 3/9/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

638178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

638178 Registered No.

1. PLACE OF DEATH: 118 N. Luzerne Ave.
(a) Baltimore City, Maryland
(b) Street address 118 N. Luzerne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Luzerne Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Emily Eugene Laird

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Isaac F. Laird
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1875

8. AGE: Years 71 | Months 1 | Days 18 | If less than one day 22 hr. min.

9. Birthplace Somerset County Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Edward Parks
13. Birthplace Somerset County Md.

MOTHER
14. Maiden Name Miranda Townsend
15. Birthplace Somerset County Md.

16 (a) Informant Linda W. Laird.
(b) Address 1712 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Balto. County Md.

18 (a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) (Date received by Registrar) (b) (Registrar)

VS MAR 8 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 46 to Mar 6 46, and that I last saw h[illegible] alive on Mar 6 1946

Immediate cause of death	Duration
Hypostatic pneumonia	
Due to Cerebral Hemmorhage	
Due to	
Other Conditions Chron. nephritis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Tinsley M. D.
Address 2936 E. Balt Date signed Mar 7 46

Handwritten or original entries and legibly.

G38179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G38179

Correct age if carelessly important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 OAKLEY AVE
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 BAKER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS MILLER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife SADIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 46 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation BIKE MAKER
11. Industry or business

FATHER
12. Name ISAAC GOLLEN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name GOLDIE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-8-46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location GERMAN HILL RD

18 (a) Funeral director JACK LEWIS INC.
(b) Address 1439 E. BALTO. ST

19 (a) Filed for record MAR 8 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4 1946, to 3/7 1946, and that I last saw h[illegible] alive on 3/6 1946.

Immediate cause of death: Cardiac failure — Duration: 2 days
Due to Pneumonia
Due to Carcinoma of Gall Bladder
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 2/16/46
Major findings of operation: Carcinoma of Gall Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm Roffe
Address 1801 Eutaw Pl. Date signed 3/8/46 M. D.

T. Raffel

G38180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38180

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 S. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Will H. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/6/1886

8. AGE: Years	Months	Days	If less than one day
59	8	10	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Rebecca Cummings
(b) Address 36 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Ellwood A. Stiles
(b) Address 1000 Edmondson Ave

19 MAR 8 - 1946 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 6 - 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19- 1946 to 3-6- 1946, and that I last saw h[illegible] alive on 3-6- 1946

Immediate cause of death Hypertensive Cardio-Vascular disease

	Duration
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 611 N Caroline Date signed 3-7-46

VS 150

G38181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered G38181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Brooks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Gloucester Co. Va
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Henry Brooks
13. Birthplace Va

MOTHER
14. Maiden Name Susie ?
15. Birthplace Va

16 (a) Informant Rae Brooks
(b) Address 715 Harlem Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Antioch Park
Location Baltimore Co

18 (a) Funeral director Mrs Geo E Pollard
(b) Address 1181 Druid Hill Ave

19 (a) MAR 8 - 1946 by registrar (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946 at 8:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion Left Old Myocardial Infarct

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 3-1-46

G38182 G38182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No.

Please answer all questions as completely as possible. The causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Winters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 10 - 1886

8. AGE: Years	Months	Days	If less than one day
60 61	4	27	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lena Nichols
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Salutation Meth. Prot. Ch.
Location Baltimore Co.

18 (a) Funeral director Wm. H. Holland
(b) Address 6 N. Gay St.

19 MAR 8 - 1946 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to March 6 1946, and that I last saw h[illegible] alive on March 6 1946.

Immediate cause of death	Duration
respiratory failure	
Due to Arteriosclerosis Coronary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. McCrumb Jr M.D.
Address Univ. Hosp. Date signed 3/4/46

G38183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G38183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3321 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Buena Vista Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosemary Tracey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James Elmer Tracey

6 (c) If alive, give age 42 yrs

7. Birth date of deceased (mo., day, yr.) Feb. 18-1904

8. AGE: Years 42 Months 7 Days 19 If less than one day hr. min.

9. Birthplace Durkley Co. S. Virginia (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Hardy Fillman Triggs
13. Birthplace S. Virginia

MOTHER
14. Maiden Name Belle Viola —
15. Birthplace Unknown

16 (a) Informant James E. Tracey
(b) Address 3512 Buena Vista Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9-1946 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 - 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7- 1946, at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to March 1946.
and that I last saw h[illegible] alive on 5 Mar 1946

Immediate cause of death Hypertensive Cardiovascular Renal disease — Duration 2 yrs

Due to Malignant Hypertension (Congenital Congenital Congenital) — Duration 2 yrs

Due to Arteriolar nephrosclerosis — Duration

Other Conditions Pharyngitis ? (? Streptococcic) — Duration 3 days

(Include pregnancy within 3 months of death)

Date of operation November 7, 1945

Major findings of operation: Normal findings (? Interstitial pancreatitis)

of autopsy: None

PHYSICIAN: Underline the cause to which death should be assigned statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Richard Engstrom M. D.
Address Hosp for Women Date signed 7 Mar 46

X

G38184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

G38184 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd. & Herring Run.
(c) Hospital or institution Lyndenham Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RUR. and give town)
(d) Street No. 223 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Asper Fitze
3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-20-4101

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Goldie E. Fitze
6 (c) If alive give age 57 years
7. Birth date of deceased (mo., day, yr.) Oct. 22, 1886
8. AGE: Years 59 58 Months 4 Days 17 16 If less than one day hr. min.
9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Consolidated Cold Storage

FATHER
12. Name Amos Fitze
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Eliz. Wandrell
15. Birthplace Pennsylvania.

16 (a) Informant Goldie E. Fitze
(b) Address 223 Scott St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9. 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City
18 (a) Funeral director Wm. Mus. John W. Teufel's Son
(b) Address 801 W. Fayette St
19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 - 1946 Westminster, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1946, at 4 00 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1946, to 3-7 1946, and that I last saw him alive on 3-7 1946.

Immediate cause of death: Diphtheria, Pharyngeal — Duration
Due to Broncho-bronchial
Due to Arteriosclerotic Heart Disease
Other Conditions Chronic Bronchitis
(Include pregnancy within three months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elijah Spagnus
Address Lyndenham Hosp. Date signed 3-9-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

G38185

Please write the causes of death clearly and legibly. The age is especially important. Physicians: please write carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Sulgrave Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---1.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Sulgrave Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Edward A. Schoolfield

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Grayce B. Craver
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) April 7, 1879

8. AGE: Years	Months	Days	If less than one day
66	10	29	-- hr. --- min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business J. W. Masury & Sons, Inc

FATHER
12. Name H. H. Schoolfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Tillson
15. Birthplace Massachusetts

16 (a) Informant Mrs. Grayce B. Schoolfield
(b) Address 1808 Sulgrave Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meats and Son
(b) Address 805 N. Calvert Street
(c) (Date received by Registrar) (Registrar)

MAR 8 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1945 to Mar 6 1946, and that I last saw h[illegible] alive on Mar 6 1946.

Immediate cause of death	Duration
Edema of lungs	6 hrs
Due to Angina pectoris	
Due to	
Other Conditions Hemiplegia 1943	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 115 Eager St Date signed 3/8/46 M. D.

VS 150

G38186

AB-99685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G38186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 117
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Doey Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Lilly Banks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25- 1895

8. AGE: Years	Months	Days	If less than one day
50	4	11	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Loading Ships
11. Industry or business

FATHER
12. Name Yale Banks
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Jones
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md
18 (a) Funeral director Robert Williams
(b) Address 1515 McElderry St
19 MAR 8- 1946 Filed by me Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6- 1946 at 5.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4- 1946 to 3-6- 1946 and that I last saw h. alive on 3-6- 1946

Immediate cause of death	Duration
Pneumonia, Lobar	4 days
Due to	
Due to	
Other Conditions	4 days.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address Balto City Hosp Date signed 3-6-46

VS 150

Please write the causes of death clearly and legibly. Answers to questions are especially important. Physicians: please write clearly and legibly. Use only black ink. Typewriter supplied.

G38187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c ✓

Registered No. G38187

Write the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:
Ventura Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5701 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE P. HILL

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William George Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1868

8. AGE: Years	Months	Days	If less than one day
77	5	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James F. Pearson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Eugenia Farrow
15. Birthplace

16 (a) Informant Mr. J. Pearson Hill
(b) Address 5701 Roland Ave.

17 (a) Removal (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Smyrna, Del.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 8 1946

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 3/8 1946, and that I last saw h[illegible] alive on 3/4 1940.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	2
Due to	
Due to	
Other Conditions Hypertensive Vascular Disease	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Zach R. McGinn M.D.
Address 6 E Read St Date signed 3/8/46

X

G38188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89a

G38188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rds.
(c) Hospital or institution Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lupton (nee Plasek)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilbur Lupton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1892

8. AGE: Years 53 | Months 54 | Days 10 | 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Plasek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Plasek
15. Birthplace Czechoslovakia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 3-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brochon
(b) Address 1004 Eastern Ave

19 (a) (b)
(Date received by local registrar)

APR 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1946, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1946 to 3-6 1946 and that I last saw her alive on 3-6- 1946

Immediate cause of death: Pneumococcic Meningitis — Duration

Due to: Bilateral Otitis Media

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchijah Spragins M.D.
Address Sydenham Hosp. Date signed 3-6-46

X

Please write the causes of death clearly and legibly. Exact age is especially important. Physicians: please write as directed. The information supplied...

G38189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

G38189 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Fleet Str
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Fleet Str
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Ordakowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rose Stargynske

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9-1886

8. AGE: Years 59 Months 7 Days 28 If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Jacob Ordakowski
13. Birthplace Poland

MOTHER
14. Maiden Name Yurk
15. Birthplace Poland

16 (a) Informant Daniel J. Ordakowski
(b) Address 2502 Fleet Str

17 (a) Burial (b) Date thereof Mar 9-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location O'Donnell St

18 (a) Funeral director Wm S. Falkowski
(b) Address 2007 Eastern Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 2.9. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946 to March 5 1946, and that I last saw him alive on March 5 1946.

Immediate cause of death	Duration
Carcinoma of Lung	10 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Swidler M.D.
Address 170 E. Fayette St Date signed 3/12/46

V MAR 8 - 1946 Hunter & Williams, M.D.

G38190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G38190 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days): 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Linden Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID G. DAVIES

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mabel U. Davies
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 4, 1882

8. AGE: Years	Months	Days	If less than one day
63	8	3	hr. min.

9. Birthplace: Wales England
(Town, county, and state)

10. Usual Occupation: Bookkeeper

11. Industry or business: Revere Copper & Brass Co.

FATHER
12. Name: William A. Davies
13. Birthplace: Wales England

MOTHER
14. Maiden Name: Mary Phillips
15. Birthplace: Wales England

16 (a) Informant: Mrs. Mabel U. Davies
(b) Address: 2426 Linden Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/8/46 (month) (day) (year)
(c) Cemetery or crematory: East Oak Grove
Location: Morgantown, W. Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore Md.

19 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1946, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6 1946 to 3-7 1946 and that I last saw him alive on 3-7 1946.

Immediate cause of death: Respiratory failure — Duration

Due to: Cerebral edema & Hemrd. Intracranial Pressure

Due to: Frontal Lobe Tumor (Spongioblastoma multiforme)

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 3-7-46

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Eugene R. Cromer M.D.
Address: Univ. Hosp. Date signed 3-8-46

VS 150

X

G38191 ✓ G38191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 Whitfield Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Whitfield Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Sterling Ewing

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	3	hr. min.

9. Birthplace Scotland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James I. Ewing
13. Birthplace Scotland

MOTHER
14. Maiden Name Elixabeth Agnew
15. Birthplace Scotland

16 (a) Informant Mr. Ewing W. Brand
(b) Address 16 Whitfield Rd.

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lakeside
Location Cleveland, O.

18 (a) Funeral director John B. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943, to March 8 1946, and that I last saw her alive on 3/5 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: Instantly

Due to: Arterio-Sclerosis — Duration: Years

Due to: Myocarditis — Duration: Years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Brady
Address 1403 Park Ave. Date signed 3/8/46

VS 150

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Information is especially important.

G38192

Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G38192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1848 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1848 Division St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eva C. White

3 (b) If veteran, name war —
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife George A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 4, 1914
8. AGE: Years 32 | Months 1 | Days 42 | If less than one day hr. min.
9. Birthplace Rockville, Va (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER
12. Name Robert Davenport
13. Birthplace Rockville, Va

MOTHER
14. Maiden Name Ellen Jones
15. Birthplace Rockville, Va

16 (a) Informant George A. White
(b) Address 1848 Division St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3. 9. 1946 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Rockville, Va
18 (a) Funeral director Mrs. George A. White
(b) Address 1831 Druid Hill Ave

MAR 8 — 1946 (Date rec'd by registrar) (b) [illegible]

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 12:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1946 to Mar 6 1946, and that I last saw h[illegible] alive on Mar 6 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to Hypertension	
Due to Fall	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1473
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Mar. 1 at 11:00 P.M.
(c) Where did injury occur? [illegible] Baltimore St
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? —
(Specify type of place)
(e) Means of injury Fell to floor in her home.
23. Signature Howard J. Sheeley M.D.
Address 1543 Pennsylvania Ave Date signed 3/7/46

Howard J. Sheeley M.D. Coroner of Balto. City

G38193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G38193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 250 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 250 Robert St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Beale Williams

3 (b) If veteran, name war /

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1885

8. AGE: Years 60 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Tappahannock, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Horace Beale
13. Birthplace Tappahannock, Va

MOTHER
14. Maiden Name Mildred Newton
15. Birthplace Tappahannock, Va

16 (a) Informant Cassie Derricks
(b) Address 250 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director Guy George A. Hallard
(b) Address 1631 Druid Hill Ave.

MAR 8 - 1946 (Date received) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1946 to Mar. 7 1946, and that I last saw h[illegible] alive on Mar. 7 1946

Immediate cause of death Septicemia — Duration 3 wk.

Due to 2nd Degree Burn of Right Leg

Due to

Other Conditions Hypertension Cerebral Thrombosis Senile (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 14/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Feb 17 1946
(c) Where did injury occur? 250 Robert St Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burned by hot poker

23. Signature [illegible] M. D.
Address 1543 Penn. Ave. Date signed 3/8/46

Approved: Robert Lee Graham M.D.

VS 150

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G38194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

G38194 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as legibly as possible. Your certificate is important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 West Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 West Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HATTIE SNYDER WELLENER (WELLENER)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry Wellaner
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.): June 5th. 1864

8. AGE: Years 81 | Months 9 | Days 1 | If less than one day ********** min.

9. Birthplace: Frederick County Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Samuel Snyder
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Eliza J. Rice
15. Birthplace: Maryland

16 (a) Informant: Mr. John G. Pentz
(b) Address: 1824 West Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Frederick Maryland

18 (a) Funeral director: C. B. Shepherd & Son
(b) Address: 1300 Eutaw Place

19 (a) [illegible] Washington Williams, M.D.
MAR 9 - 1946
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 th. 1946 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1946 to March 6 1946 and that I last saw her alive on March 5 1946

Immediate cause of death	Duration
Coronary Thrombosis	8 days
Due to Hypertensive Cardio-Vascular Disease	?
Due to Generalized Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None;

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 2401 West North Ave. Date signed 3/8/46

Dr. PF. Lerner

G38195 — Horatel ✓ — G38195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1946 Sponsor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Horatel

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-9074

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4-1918

8. AGE: Years	Months	Days	If less than one day
28	-	2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Contractor Trade Shows

11. Industry or business Exhibiting Industry

FATHER
12. Name Isidor Horatel
13. Birthplace Md

MOTHER
14. Maiden Name Eva A. Sabrok
15. Birthplace Md

16 (a) Informant John Horatel
(b) Address 1946 Sponsor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. B. Shippett & Son
(b) Address 300 Eutaw Place

19 (a) Date received MAR 9 1946 (b) (Registrar) Timothy F. Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1946 at 2:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1946 to 3-6 1946 and that I last saw h/s alive on 3/6 1946.

Immediate cause of death Cardio Renal failure due to Chronic Nephritis — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morton Strauss

Address St. Agnes Hosp. Date signed 3/7/46

VS 150

X

Directions for filling out this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

G38196 BALTIMORE CITY HEALTH DEPARTMENT G38196
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 10 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rockhaven Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward B. Gallup

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband/wife Bessie Pearl Gallup
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-1884

8. AGE: Years 62 | Months - | Days 18 | If less than one day hr min

9. Birthplace Maryland - Balto.
(Town, county and state)

10. Usual Occupation Conductor
11. Industry or business B. & O. R.R.

FATHER
12. Name Edward Gallup
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie Lawyer
15. Birthplace Md.

16 (a) Informant Jennie O. Gallup
(b) Address Pasadena, Md.

17 (a) Burial (b) Date thereof 3-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. O. Klapproth & Son
(b) Address 300 Eutaw Place

19 (a) (Date rec'd by registrar) (b)

MAR 9 1946 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1946 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1946 to 1946, and that I last saw h. alive on 3-8 1946.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hendrickson M.D.
Address 5.06 N. Date signed 3/8/46

G38197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G38197 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3257 Chestnut Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3257 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles White. Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-2995

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower.

6 (b) Name of husband or wife Dora White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1874

8. AGE: Years	Months	Days	If less than one day
71	9	6	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles P. White
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Caroline Fisman
(b) Address 3257 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Frederick Road

18 (a) Funeral director P. Simonds & Sons
(b) Address 3615 [illegible] Baltimore, Md.

MAR 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1946, at 1 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1946, to 3-7 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma of Oesophagus	2 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature P. J. Flynn M. D.
Address 1800 N. Charles St Date signed 3-8-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G38198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 West Lee Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1923

8. AGE: Years: 22 | Months: 7 | Days: 15 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Truck Helper

11. Industry or business Fruit Business

FATHER
12. Name Julius R. Web
13. Birthplace Va.

MOTHER
14. Maiden Name Eva Harris
15. Birthplace Va.

16 (a) Informant Rev. Robert Stevens
(b) Address 16½ E. York St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny Inc.
(b) Address 715 Light St.

19 (a) [illegible] (Date received by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1946, at 3 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-8-46 2:45 A. M.
(b) Where did injury occur? 919 S. Hanover Street
(c) Did injury occur at home, on farm, industrial place, in public place? Friend's home While at work? NO
(d) Means of injury Stabbing

23. Signature Benedict A. Petarelli M.D.
Medical Examiner.
Date signed 3-8-46.

VS 151

G38199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G38199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard LeC. Spicer

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7793

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Nina Cassimus

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 23, 1874

8. AGE: Years 71 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Finish Carpenter

11. Industry or business

FATHER
12. Name Jerima Spicer
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Keen
15. Birthplace Md

16 (a) Informant Mrs Nina Spicer
(b) Address 1929 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Old Trinity
Location Cambridge, Md.

18 (a) Funeral director John F. Denny Inc
(b) Address 718 Light St.

19 (a) (Date rec'd by registrar) (b)

MAR 9 - 1946

Hunting for Hallowell, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th 1946, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1946 to March 5 1946, and that I last saw [illegible] alive on March 5 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage.	
Due to Hemorrhagic arteriosclerosis.	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Fruchtman

Address 1319 Light St. Date signed 3/11/46

83a

Please write the causes of death clearly and legibly. Physicians: please write correct age as especially important.

G38200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. G38200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 N. Kamundo
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Ramenk (Albert Kamenk)

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-9303

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Anna Ramenk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years 73 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Watchman
11. Industry or business: Canton R.R. Co.

FATHER
12. Name: — Ramenk
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mr. Albert Ihle
(b) Address: 1622 N. Bond St.

17 (a) Burial (b) Date thereof 3 11 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: "

18 (a) Funeral director: Philip Herwig Sons
(b) Address: 2024 Orleans St

19 (a) (Date rec'd by registrar) (b) Baltimore, Md.

MAR 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946, at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 7, 1946
(b) Where did injury occur? 723 N. Kamundo
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Burning by gas.

23. Signature Benedict Shtarbe M.D.
Medical Examiner.
Date signed 3-8-46

G38201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G38201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23d
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Calvert St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Richard Stewart

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/23/1873

8. AGE: Years 72 | Months 0 | Days 10 | If less than one day — hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business Mercy Hospital

FATHER
12. Name Charles Stewart
13. Birthplace Md

MOTHER
14. Maiden Name Alexine Sparton
15. Birthplace Md

16 (a) Informant Henry N. Stewart
(b) Address Wainon Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar for Williams MD

MAR 1946

MS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/46 19..., at 5 19 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1946 to 3/5 1946 and that I last saw him alive on 3/5 1946

Immediate cause of death Pneumonia Lobar — Duration 3days

Due to Hypostasis due to Cardiac Decomp — 3wks

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan L. Kelly Jr. M. D.

Address Mercy Date signed 3/5

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information asked for must be carefully supplied.

G38202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38502 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry N. Walls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Minnie F. Walls
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5th 1876

8. AGE: Years	Months	Days	If less than one day
70	0	3	hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Own

FATHER
12. Name Charles Walls
13. Birthplace Md.

MOTHER
14. Maiden Name Laura (Unknown)
15. Birthplace Md.

16 (a) Informant Minnie F. Walls
(b) Address 1801 N. Gay St.

17 (a) Burial (b) Date thereof 3/11/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~[redacted]~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) (Registrar for Baltimore, Md.)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 March 1946 at 2 40 A M

21: I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardiac Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.
Date signed 8 March '46

X

G38203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G38203 Registered No. 516

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 135 N Monastery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David E Coburn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28. 1882

8. AGE: Years	Months	Days	If less than one day
63	6	9, 11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Self

FATHER
12. Name Unknown Coburn
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Lelton Conkodt
(b) Address 135 N Monastery Ave

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery London Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul st

19 (a) (Date rec'd by registrar) by Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1945 to Mar. 8 1946, and that I last saw h[illegible] alive on Mar. 8 1946.

Immediate cause of death	Duration
Adeno carcinoma Prostate Gland	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature DC MacLaughlin
Address 400 N. Payson St. Date signed M. D. 3/8/46

VS 150 MAR 9 - 1946

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use typewriter if convenient.

RODRIGUEZ ✓

638204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 638204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 St. Paul St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Rodriguez

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Newborn			1 hr. ..... min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School MAR 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 MAR 9 1946 Thurston Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946 at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Prematurity

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 28 1946

5348 X

G38205

Found - 537 Carmel alley (over)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G38205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Caldera sundmann
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Carter alias George Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60?41			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 7 1946

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 9 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1946, at 11:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Cardiac Failure

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stitaralic M.D.
Medical Examiner.
Date signed 2-15-46

8347

X

G38206

AB-58170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164E

Registered No. G38206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs- 6mos-27days
(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Russia

3 (a) FULL NAME Alexander Amelio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. ?- 1880

8. AGE: Years 65 | Months 4 | Days ? | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Nikibber or Nikibhov Amelio
13. Birthplace Russia

MOTHER
14. Maiden Name Uliana Gerasimenko or Vliana Gerasimenko
15. Birthplace Russia

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School MAR 8 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 9 1946 (Date rec'd by registrar) for Williams, M.D. Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH March 5- 1946; at 11.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1940 to 3-5- 1946, and that I last saw him alive on 3-5- 1946

Immediate cause of death: Cachexia — Duration 14 mo

Due to: Fracture of both femurs, pelvis + humerus — 1½ mo

Due to: Pneumonia, lumbar

Other Conditions: Cystitis

(Include pregnancy within 3 months of death)

Date of operation 1-24-46 & 2-6-46

Major findings of operation: Sarcoma

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Suicide
(b) Date of occurrence 1½ mo ago 1-20-46 at M
(c) Where did injury occur? Balto. (City or town) md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Bath. Room While at work? no (Specify type of place)
(e) Means of injury Jumped from 2nd flr.

23. Signature [illegible] M. D.
Address Balto. City Hosp. Date signed 3-7-46

VS 150

6349 To be approved by Medical Examiner Benedict Skotarchi M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38207

BALTIMORE CITY HEALTH DEPARTMENT

TN 93672

CERTIFICATE OF DEATH 46E

Registered No. G38207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Gatewood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15th 1879

8. AGE: Years 66 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Gatewood
13. Birthplace Va.

MOTHER
14. Maiden Name Nora ? (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 8 1946

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 9 1946 (Date rec'd by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 3rd. 1946 at 3.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17/45 19 to Mar 3/46 19 and that I last saw him alive on March 3rd 19 1946

Immediate cause of death: Carcinoma of Colon — Metastasis to liver — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. R. Jennings M. D.

Address Baltimore City Hosp Date signed 3-7-46

VS 150

5352

X

G38208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G38208

HB 27918

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 3 23 26
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County:
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Smith Julius

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1898

8. AGE: Years 47 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Cleveland Smith(d)
13. Birthplace ?

MOTHER
14. Maiden Name Luvenia? (d)
15. Birthplace ?

16 (a) Informant Balto. City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School MAR 8 1946
Lo
18 (a) Funeral director Commissioner of Health
(b) Address

MAR 9 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1946 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31, 1937 Feb. 24, 1946 and that I last saw him alive on Feb. 24, 1946

Immediate cause of death: Uremia — Duration

Due to HCVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret Bond, M. D.
Address B C H Date signed 2/28/46

VS 150

9351

X

G38209 G38209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

41

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hadwood & Dolcum Sts.
(c) Hospital or institution: University Hospital 2/1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 N. Bruce (rear house)
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Albertus Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 23 Feb 1946

8. AGE: Years — | Months — | Days 4 | If less than one day hr. min.

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation New born

11. Industry or business New born

FATHER
12. Name Bessie Davis
13. Birthplace Manning, So. Carolina

MOTHER
14. Maiden Name Lottie Walker
15. Birthplace Manning, So. Carolina

16 (a) Informant Lottie Walker Davis
(b) Address 1115 N. Bruce.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAR 8 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 9 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Atelectasis fetal	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George M Lemmon M. D.
Address Clin. Hosp. Date signed

5350 X

G38210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

G38210 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5008 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Clarence Joh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1898

8. AGE: Years	Months	Days	If less than one day
48	11	15	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Gardener Jewish Sch

11. Industry or business

FATHER 12. Name Fred C. J.

13. Birthplace Md.

MOTHER 14. Maiden Name Louise Stahl

15. Birthplace Md.

16 (a) Informant Annie A Joh

(b) Address 5008 Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9 1946 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location 3801 Frederick Rd

18 (a) Funeral director Harry N Weagle

(b) Address 401 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 9 - 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1946 at 2:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1946 to 3-6 1946 and that I last saw h[illegible] alive on 3-6 1946

Immediate cause of death: Acute Hemorrhagic Pancreatitis & Erosion into Duodenum

Duration: 36 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-3-46 - 2-12-46

Major findings of operation: as above.

PARTIAL RESECTION - 2nd portion of duodenum

Acute Hemorrhagic Pancreatitis

of autopsy: [illegible]

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address St. Agnes, Bo. Date signed 3/6/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

G38411 ✓ G38411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Druid St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME WILLIAM HOWARD HAGUE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frances Hague
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): ~~December~~ 12/10/1859

8. AGE: Years 86 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace: Indiana (Town, county, and state)
10. Usual Occupation: Wholesale Dry Goods
11. Industry or business: Retired 30 yrs.

FATHER
12. Name: Unknown "
13. Birthplace

MOTHER
14. Maiden Name: "
15. Birthplace "

16 (a) Informant: Mr. Albert T. White Fla.
(b) Address: 2223 W. Beaver St., Jacksonville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge Cem.
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Signature of Funeral Director) (b) Registrar

MAR 9 1946

VS 151

Hunting for Millionaires

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 6 1946, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Dis death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Carbon monoxide poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 6 1946 M.
(b) Where did injury occur? 813 Druid St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Burning by gas

23. Signature: Benedict Stitely M.D. Medical Examiner.
Date signed 3-6-46

X

G38212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G38212 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 South St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Frances Hague

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William H. Hague

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1864

8. AGE: Years 82 | Months 0 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Tenn. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business -

FATHER
12. Name Edward Oates
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Tregay
15. Birthplace England

16 (a) Informant Mr. Albert T. White
(b) Address 2223 W. Beaver St. Jacksonville Fla.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem. Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 9 - 1946 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar - 6 1946, at 9 55 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon monoxide poisoning

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 6, 1946 M.
(b) Where did injury occur? 813 South St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas

23. Signature Benedict Shitarski M.D. Medical Examiner.
Date signed 3-6-46

VS 151

G38213

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38213 Registered No.

CERTIFICATE OF DEATH 937

Please write the causes of death clearly and legibly: Physicians: please write all answers; abbreviations are especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs M.M.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 E. 21st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James D. Morris

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Bertha M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1897

8. AGE: Years	Months	Days	If less than one day
48	11	29	hr. min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Engraver
11. Industry or business Southern Standard Co

FATHER
12. Name Daniel Morris
13. Birthplace Ark.

MOTHER
14. Maiden Name Delphia Marcum
15. Birthplace Ky.

16 (a) Informant Mrs. Bertha Morris
(b) Address 716 E. 21st St.

17 (a) Removal (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Helena Barrings Arkansas.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Ave. Balto. Md.

19 (a) MAR 9 – [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-46 19 , at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7-1946 to 3-7-1946 and that I last saw him alive on 3-7-1946.

Immediate cause of death	Duration
Acute Myocardial insufficiency	
Due to Coronary Thrombosis	
Due to Coronary sclerosis & Myocardial fibrosis.	
Other Conditions Pulmonary Emphysema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Reder M. D.
Address Sinai Hosp Date signed 3/7/46
Howard J. Greenwald, M.D.

VS 150

G38214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a G38214 File No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2418 W. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Martha E. Tyrrell

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: FeMale
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John L. Tyrrell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1877

8. AGE: Years 68 | Months 5 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James E. DeCoursey
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Matilda W. Cornwaith
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Joseph L. Tyrrell
(b) Address: 2418 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) MAR 9 - 1946 (b) Registrar: Millicent, Md.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 7, 1946, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19..., to 3-7-1946, and that I last saw h[illegible] alive on 3-7-1946.

Immediate cause of death: Paraplegia — Duration:
Due to: Cerebral Hemorrhage — 6 Wks.
Due to: Hypertension — Unknown
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: L. B. Eusor M. D.
Address: 7201 York Rd. Date signed 3-8-46

G38215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

G38215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 McElderry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 E.Phila. Rd.Harford Co. M
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Zieman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Herman Zieman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.10,1869

8. AGE: Years 76 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs.Helen Thomas
(b) Address 3020 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar,12/46 (month) (day) (year)
(c) Cemetery or crematory Trinity Cem.
Location Harford Co.Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 9 - 1946

Form 190 Huntingtown Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 19 46 to 3/8 19 46, and that I last saw h alive on 3/8 19 46.

Immediate cause of death Pulmonary Edema
Due to Cerebral Thrombosis

Duration
1 year

Due to

Other Conditions Malaria

4 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter P. Silkworth M. D.

Address 69 E McElderry St Date signed 3/9/46

G38216 ✓ G38216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 Hamilton Avenue
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 11 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 Hamilton Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Elmer Galloway

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Janet C. Galloway
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 1 1873

8. AGE: Years 73 | Months 0 | Days 5 | If less than one day: hr. min.

9. Birthplace Balto Co
(Town, county and state)

10. Usual Occupation Cashier - Prisoners Aid

11. Industry or business

FATHER — 12. Name Aquilla Galloway
13. Birthplace Balto Co.

MOTHER — 14. Maiden Name Mary E. Kelley
15. Birthplace Balto Co

16 (a) Informant Mrs Janet C. Galloway (wife)
(b) Address 827 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-46 (month) (day) (year)
(c) Cemetery or crematory Greenmt
Location Balto Md

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6 1946, at 8:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1945 to Mar. 6 1946, and that I last saw h[illegible] alive on Mar. 6 1946

	Duration
Immediate cause of death: Coronary occlusion (Thrombosis)	10 days
Due to: Arterio sclerosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Robt. K. Heyd M. D.
Address Mercy Hosp. Date signed 3/9/46

Hunting for Millions, Md

G38217

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38217

CERTIFICATE OF DEATH 83a

Registered No.

Write the cause of death clearly and legibly. Physicians: please write the correct age as especially important. The certificate must be typewritten or executed with indelible pencil.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Parkside
(c) Hospital or institution: Wheeler Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Parkside (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia L. Stobbs

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar-4-1860
8. AGE: Years 86 | Months 0 | Days 4 | If less than one day hr. min.
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Brice S. Stobbs
13. Birthplace Baltimore

MOTHER
14. Maiden Name Eleanor White
15. Birthplace Baltimore

16 (a) Informant Mrs Jos. M. Stobbs
(b) Address 2116 Mt Royal

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar-11-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location STEWART & MOWEN COMPANY

18 (a) Funeral director (or person in charge) (W. F. WOODEN SUC.) 108 W. NORTH AVENUE
(b) Address

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946, at 4 a M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1946 to March 8 1946, and that I last saw her alive on March 7 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Sidney Thomas M. D.

Address 714 Med. Arts Bldg Date signed March 9/46

VS 150

G38218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G38218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ETHEL BLANCHE NEUMANN

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis C. Neumann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1890

8. AGE: Years	Months	Days	If less than one day
55	7	26	hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George F. Schweizer
13. Birthplace: Md.

MOTHER
14. Maiden Name: Octavia Jones
15. Birthplace: Md.

16 (a) Informant: Mr. Louis C. Neumann
(b) Address: 1733 N. Washington St.

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAR 9 - 1946 (b) Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1946 at 12.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1946, to 3/8 1946 and that I last saw her alive on 3/8 1946

Immediate cause of death: Bronchopneumonia — Duration

Due to:

Due to:

Other Conditions: Rheumatic Heart Disease with Mitral Stenosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Martin E. Strobel M. D.
Address: Md. Gen'l. Hospital Date signed 3/8/46

VS 150

107

G38219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G38219

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md. 15.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Edgewood Rd.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country

3 (a) FULL NAME Jensen, Karl Johan

3 (b) If veteran, name war
3 (c) Social Security Account No. ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Catherine Hendricks
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 19, 1885

8. AGE: Years 60 | Months 7 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace ? Norway
(Town, county, and state)
10. Usual Occupation Master
11. Industry or business Seafarer

FATHER
12. Name Karl Alfred Jensen
13. Birthplace Norway

MOTHER
14. Maiden Name Janne Gurine
15. Birthplace Norway

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 9 - 1946 (Date rec'd by registrar) by Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 8 1946, at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5 1946 to Mar. 8 1946, and that I last saw him alive on Mar. 8 1946.

Immediate cause of death Carcinoma of larynx — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 3/8/46
US Marine Hospital, Balto, Md.

C38220 BALTIMORE CITY HEALTH DEPARTMENT X ✓ C38220

CERTIFICATE OF DEATH 44 B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 Maple Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARL M. DINKELMAN (Carl Metzger Dinkelman)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillian C. Dinkelman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1897

8. AGE: Years	Months	Days	If less than one day
48	9	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Wholesale Jewelery Business
11. Industry or business Self

FATHER
12. Name Charles H. Dinkelman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lillie Metzger
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Lillian C. Dinkelman
(b) Address 1235 Maple Ave., Arbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 9 - 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/ 1946, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946 to 3-8 1946 and that I last saw him alive on 3-7 1946

Immediate cause of death	Duration
Hodgkins disease	
Due to	
Due to	
Other Conditions Partial Hydrothorax (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Generalized Hodgkins

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Gasaway M. D.
Address Date signed

VS 150

X

G38221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38221 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 S. Washington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 S. Washington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Zurkiewicz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Martin Zurkiewicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1 1887

8. AGE: Years 59 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Paul Kawalewski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Mary Denyack
(b) Address 243 S. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Raysgrave Pa.

18 (a) Funeral director John J. Weber
(b) Address 401 S. Chester Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MAR 9 - 1946

MEDICAL CERTIFICATION 425

20. DATE OF DEATH March 9 1946 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1945 to March 9 1946; that I last saw her alive on March 9 1946

Immediate cause of death TERMINAL BRONCHO PNEUMONIA — Duration 2 DAYS

Due to CHRONIC NEPHRITIS — 5/1/45

Due to DIABETES MELLITUS — 4/29/45

Other Conditions CEREBRAL HEMORRHAGE — 5/1/45
CHRONIC CHOLECYSTITIS ??
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Jos. F. Donga
Address 209 Albert St Date signed 3/9/46 (M. D.)

X

638222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 638222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 Pierce Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1711 Pierce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARA JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Homemaker

11. Industry or business

FATHER
12. Name Abraham Brown
13. Birthplace Hampton Va

MOTHER
14. Maiden Name unknown
15. Birthplace Hampton Va

16 (a) Informant Blanche Bell
(b) Address 1711 Pierce St

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. Co. Md.

18 (a) Funeral director Chas H. Alexander
(b) Address 922 N. Mount St

19 MAR 9 - 1946 Wallace Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/46 19 at 4.40 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos R Davis M.D.
Medical Examiner.
Date signed 3/6/46

G38223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G38223 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age as carefully important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Cornell
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Cornell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hall

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/16/1883

8. AGE: Years 62 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henson Brooks
13. Birthplace Md

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Md

16 (a) Informant Agnes Hall
(b) Address 613 Cornell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

MAR 9 - 1946 (Date rec'd by Registrar) (b) Hagerstown, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1946 to 3/7 1946 and that I last saw her alive on 3/7 1946

Immediate cause of death Pneumonia
Myocardial Degeneration

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trauberman M. D.
Address 712 W Lee Date signed 3/9/46

X

G38224 G38224

BALTIMORE CITY HEALTH DEPARTMENT

CWK-98818 **CERTIFICATE OF DEATH** 30 D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 12-
(e) Length of stay in Baltimore (yrs., mos., or days) 69 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 864 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Hayes Reed

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October ? 1888

8. AGE: Years	Months	Days	If less than one day
57	5 ?	?	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Reed (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Fannie ? (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A B Co Md
18 (a) Funeral director Sarah L Brownston
(b) Address 1 W Mount Vernon Pl
MAR 9 - 1946 Washington Baltimore MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1946 to Mar. 7 1946, and that I last saw h. in alive on Mar. 7 1946

Immediate cause of death	Duration
Cerebellar atrophy	?
Due to	
Due to	
Other Conditions Syphilitic aortitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: none
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 3-8-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38225 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3524 Elmley Ave.,
(c) Hospital or institution:

8-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Elmley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma T. Heim

3 (b) If veteran, name war

3 (c) Social Security Account No:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1878

8. AGE: Years	Months	Days	If less than one day
67	5	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick S. Kanzler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Herrmann
15. Birthplace Germany

16 (a) Informant Mrs. Albert Mackin
(b) Address 3524 Elmley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Schwartzs
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 MAR 9 - 1946 (Date rec'd by Registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to March 8 1946, and that I last saw her alive on March 8 1946.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Hypertensive Cardio-Vascular Disease	9 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. M. Jacobson M. D.
Address 2310 Eutaw Place Date signed 3-9-46

VS 150

G38226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38226 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Gold St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Gold St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lola Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Harry Hicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67 yrs			hr. min.

9. Birthplace Essex Co., Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Nelson
13. Birthplace Va.

MOTHER
14. Maiden Name Cameillia Pitts
15. Birthplace Va.

16 (a) Informant Harry Hicks
(b) Address 605 Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

MAR 9 - 1946 (Date rec'd by Registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 19 46, at 3:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 19 46, to Mar 6 19 46 and that I last saw her alive on Mar 1 19 46.

Immediate cause of death	Duration
Cardio Vascular Disease	6 mnts
Due to Hypertension	6 mnths
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Penna Ave Date signed 3/8/46

VS 160

G38227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3804 W. Strattmore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 W. Strattmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Norris.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife William C. Norris.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1855

8. AGE: Years 90 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William R. Sonett
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Tabitha A. Jeans
15. Birthplace Savage, Maryland

16 (a) Informant Annie L. Herbert
(b) Address 3804 W. Strattmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Maryland

18 (a) Funeral director Loring Byers
(b) Address Park & Wiltshire Ave.

19 MAR 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946 at 6 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to March 1946, and that I last saw h[illegible] alive on 3/7, 1946

Immediate cause of death: Hypostatic Pneumonia — Duration 18 hr.

Due to: Chronic Myocarditis and Senility — Duration [illegible] yrs.

Due to:

Other Conditions: Cardio Renal. Duration [illegible] yrs.
Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Hubert J. Turley M.D.
Address 917 N. Charles St. Date signed 3/9-46 M. D.

Hubert T. Turley X

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G38228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Hammonds Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Mitchell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1886

8. AGE: Years 58 | Months 8 | Days 59 | If less than one day hr. min.

9. Birthplace Brazil
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mike Mitchell
13. Birthplace Brazil

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Herman Mitchell
(b) Address 515 Hammonds Lane

17 (a) Burial (b) Date thereof 3-10-1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's
Location Jamaica, New York

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

MAR 9 - 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1946 at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1946 to 3-8 1946 and that I last saw him alive on 3-5 1946

Immediate cause of death Bronchogenic Carcinoma — Duration 1 yr 3 mo terminal

Due to Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman Pat M. D.

Address Sinai Hosp Date signed 3-8-46

VS 150

Write age if expiry important. Physicians: please write the causes of death clearly and legibly.

638229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a

Registered No. 638229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 S Luzerne Ave.
(c) Hospital or institution Bayview Hosp. Ward 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2605 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Gosztoltowicz (GOSZTOLTOWICZ)
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-01-3200

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED
6 (b) Name of husband or wife Rose Gosztoltowicz
6 (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) 7-28-94
8. AGE: Years 51 | Months 7 | Days 11 | If less than one day ... hr. ... min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel
FATHER 12. Name Mike Gosztoltowicz
FATHER 13. Birthplace Poland
MOTHER 14. Maiden Name ANTONINA ZABLOCKA
MOTHER 15. Birthplace POLAND
16 (a) Informant MRS. ROSE GOSZTOLTOWICZ
(b) Address 2605 E. FAIRMOUNT AVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL ROAD
18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Ave
19 MAR 9 - 1946 (b) Harry Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1946 at 3:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1946 to 3-8 1946.
and that I last saw him alive on 3-5 1946
Immediate cause of death Lymphatic Leukemia — Duration 1 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Weinberg M.D.
Address 2866 E. Monument Date signed 3-9-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

HAROLD WEINBERG, M.D.

G38230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G38230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 3
(e) Length of stay in Baltimore (~~yrs., mos.~~, or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County: Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6910 Copeleigh Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Graham (JOHN GRAHAM)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/46

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John A. Graham
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name FAYE ELLEN WHITE
15. Birthplace SEAL'S ISLAND MD.

16 (a) Informant John A. Graham
(b) Address 6910 Copeleigh Rd.

17 (a) BURIAL (b) Date thereof 3/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 119 W. Mt. Royal Ave.

19 MAR 9 - 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1946, at 9:45 A.M.

21. I certify that death occurred on the date above stated that I attended deceased from 3/6 1946 to 3/9 1946.
and that I last saw ~~him~~ alive on 3/9 1946

Immediate cause of death: Cardio respiratory failure
Due to: Premature birth
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frank J. Ryder M.D.
Address St Josephs Hospital Date signed 3/9/46

Please write the causes of death clearly and legibly. Physicians: please write the correct age if especially important.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38231 — 94a — G38431

Please write the causes of death clearly and legibly. The age is especially important. Physicians: please write carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [redacted]
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5010 Norwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary W Sloan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Chas. E. Sloan

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Aug 18 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	6	19		

9. Birthplace Jarrettsville Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Thomas H. Wiley
13. Birthplace Harford Co Md.

MOTHER
14. Maiden Name Elizabeth Wheeler
15. Birthplace Jarrettsville Md.

16 (a) Informant Chas E. Sloan
(b) Address 5010 Norwood Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12th (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Malonee Harford Co Md

18 (a) Funeral director Murphy & Kenny
(b) Address Jarrettsville Md

(c) Date received by registrar MAR 10 1946 Huntington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. **DATE OF DEATH** March 9th 1946, at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20th 1946, to March 9 1946, and that I last saw her alive on March 9th 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Coronary Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Sloan Wiley M.D.

Address Maryland G. Hospital Date signed 3/9/46

G38232 ✓ G38232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the exact age is especially important. Information supplied by the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 93 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Clearview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ann Deale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28 1852

8. AGE: Years 93 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife —

11. Industry or business

FATHER 12. Name Samuel Deale

13. Birthplace Baltimore

MOTHER 14. Maiden Name Caroline ?

15. Birthplace Baltimore

16 (a) Informant Mrs. Leonard Dressel

(b) Address 3105 Clearview Ave.

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director Leonard J. Buck

(b) Address 5305 Old Ford Rd.

19 (a) 1946 (b)
(Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946, at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 5 1946 and that I last saw her alive on March 5 1946

Immediate cause of death	Duration
Cardio. Respiratory Failure	
Due to Uraemia	
Due to Carcinoma of Bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. Martin M.D.

Address St. Joseph's Hosp Date signed 3-7-46

Clerk

G38233 — Drew ✓ G38233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. .....

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Any supplies you may require will be furnished upon request.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 West Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs Lillian C. Trew.

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Dr. Bartus Trew
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 26 1868

8. AGE: Years 77 | Months 5 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation housewife
11. Industry or business .....

FATHER
12. Name Wesley Colston.
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Funkhouser
15. Birthplace Virginia

16 (a) Informant Hospital Record
(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Henry McJunkin & Sons
(b) Address McCulloh & Eutaw Sts

19 (a) Date received 1946 (Registrar) Hamilton Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1946, at 7 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19..., and that I last saw h... alive on ..... 19...

Immediate cause of death Bronchopneumonia due to
Generalized Carcinomatosis — Duration .....

Due to Carcinoma of stomach — .....

Due to ..... — .....

Other Conditions Generalized Arteriosclerosis — .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: Generalized Carcinomatosis with Ascites

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Hyde R Agnew M. D.
Address Church Home + Hospital Date signed 3/11/46

G38234

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38234

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 4
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2637 Loyola Northway
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Rubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia
(Town, county and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Belle
15. Birthplace Russia

16. (a) Informant: Rose Rubin
(b) Address 2637 Loyola Northway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-46 (month) (day) (year)
(c) Cemetery or crematory Lonedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Son
(b) Address 1434 E Balto St

MAR 10 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946, at 8:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to Angina Pectoris

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Gratton M.D.
Medical Examiner.
Date signed March 9 1946

X

G38235 BALTIMORE CITY HEALTH DEPARTMENT G38435 Registered No.

CERTIFICATE OF DEATH 49a

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2849 Lake Avenue
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2849 Lake Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane L. Malone

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	212-05-9051

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Malone
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	4	15	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Mfgr. Hats

FATHER 12. Name John A. Miner
13. Birthplace Maryland

MOTHER 14. Maiden Name Bridget A. Banahan
15. Birthplace Ireland

16 (a) Informant Mrs. Mary A. Nies (Sister)
(b) Address 66s Dumbarton Avenue

17 (a) Burial (b) Date thereof 3/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAR 10 1946 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1946 to Mar 8 1946.
and that I last saw h[illegible] alive on Mar 8 1946.

Immediate cause of death: Anemia & Peripheral circulatory collapse — Duration
Due to: Granuloma Cell Tumor
Due to: with Metastasis
Other Conditions: wet
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M.D.
Address 5217 Harford Rd Date signed 3-14-46

X 14

G38236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G38236 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 E. Lanvale Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 E. Chase Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie M. Baader

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John H. Baader
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.): April 16, 1865

8. AGE: Years 80 | Months 10 | Days 21 | If less than one day: ##hr ##min

9. Birthplace: Philadelphia, Pa (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Guckert
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Josephine Funk
15. Birthplace:

16 (a) Informant: Mrs. Mary Nickel (Daughter)
(b) Address: 1418 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4430 Belair Rd.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) MAR 10 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7th, 1946 at 5? M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1946 to Mar. 7 1946 and that I last saw h[illegible] alive on Mar. 5 1946.

Immediate cause of death: Coronary occlusion — Duration: 12 hrs.
Due to: Arteriosclerotic C-V disease
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?: (Specify type of place)
(e) Means of injury:

23. Signature: W. H. Granger M.D.
Address: 1402 E. Lanvale St. Date signed: 3-9-46

VS 150

X

AB- G38237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G38237 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23yrs-1mos-16days
(e) Length of stay in Baltimore (yrs., mos., or days) 63yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) Baltimore City Hospitals
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bridget Hughes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 88yrs?

8. AGE: Years 88 ? Months ? Days ? If less than one day ...hr. ...min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name Daniel Hughes
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Ridge
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/11/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John Conway & Son
(b) Address 901-03 E. Fallsway

MAR 10 1946 (b) (Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8- 1946, at 1.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22-1923 19... to 3-8- 1946, and that I last saw her alive on 3-8- 1946

Immediate cause of death: Bronchopneumonia — Duration: ?

Due to:

Due to:

Other Conditions: Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hos. Date signed 3-9-46

Enter exact age in especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

VS 150

X

G38238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38238

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
—	317099961	F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1887

8. AGE: Years	Months	Days	If less than one day
59	5	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Pittsburgh Plate Glass

FATHER 12. Name George F. Smith
13. Birthplace Bangor, Maine

MOTHER 14. Maiden Name Anna E. Hanson
15. Birthplace Baltimore

16 (a) Informant Ralph Smith
(b) Address Magnolia Ave. Lutherville

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof March 11-46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey, Maryland

18 (a) Funeral director Edgar A. Guest
(b) Address Lutherville Md.

19 (a) Date received by local registrar MAR 11 1946 (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1946, at 10 45 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 3/7/46

(over)

G38239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

G38239 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Ave
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town 4203 Springdale Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nellie Boies Day

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 20, 1868

8. AGE: Years 77 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Norman Day
13. Birthplace Conn.

MOTHER
14. Maiden Name Eliza Boies
15. Birthplace Conn.

16 (a) Informant Harry S. Taylor
(b) Address 411 Woodlawn Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Fountain Hill
Location Deep River, Conn.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAR 11 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946, at 5-00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1945, to March 8th 1946, and that I last saw h.. alive on March 7th 1946

Immediate cause of death
Cirrhosis of Liver
Ascites.
Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No

Duration
2 Years
6 Years
6 Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. S. Schatzel M. D.
Address 1300 N. Calvert St. Date signed March 9 1946

G38240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G38240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 Pittsmon Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Pittsmon Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E Fiddon

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	22	hrs. min.

9. Birthplace Broadway Va
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Fiddon
13. Birthplace West Virginia

MOTHER
14. Maiden Name Nancy Manning
15. Birthplace Harrisonburg Va

16 (a) Informant Elizabeth Schreiber
(b) Address 411 Pittsmon Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Baltimore Md

18 (a) Funeral director Fulton & Son
(b) Address 1217 Gay St

19 (a) 3-11-1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946 at 5 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941 to 3/7 1946 and that I last saw h. alive on 3/6 1946.

Immediate cause of death: Cerebral Hem — Duration 3 Dys
Due to Arterio Sclerosis — 4 yrs
Due to
Other Conditions: First attack 6 mo ago.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2020 N. Clarey Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G38241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hosp. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Glyndon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Vilkas

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Vilkas

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1888

8. AGE: Years 57. Months 7 Days 4 If less than one day hr. min.

9. Birthplace Elliott City Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William F. Potts
13. Birthplace Md.

MOTHER
14. Maiden Name Mary R. Kelbaugh
15. Birthplace Pa.

16 (a) Informant John Vilkas
(b) Address 1223 Glyndon Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAR 11 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946 at 2:2 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed March 9, 1946.

VS 151

Birderbook

G38242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

Registered No. G38242

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 W. Cross st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 W. Cross st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter Birderbook

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-0002

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7th 1883

8. AGE: Years	Months	Days	If less than one day
62	3	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business at Large

FATHER 12. Name Wm Birderbook

13. Birthplace Md.

MOTHER 14. Maiden Name Marge Jordan

15. Birthplace Md

16 (a) Informant Edward J. Birderbook

(b) Address 1100 W. Cross st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)

(c) Cemetery or crematory Balto Md

Location

18 (a) Funeral director William Cook Inc

(b) Address 1 MAR 11 1946 St. Paul

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8th 1946 at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1945 to Mar 8 1946 and that I last saw h[illegible] alive on Mar 1, 1946

Immediate Cause of death	Duration
Acute Heart Failure	
Due to Chronic Heart Disease	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 3-8-46 at 8:25 AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J Glass MD M. D.

Address 936 Wellington Rd Date signed 3/8/46

VS 150

G38243 BALTIMORE CITY HEALTH DEPARTMENT G38243

CERTIFICATE OF DEATH 94 C Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dawson Transfer Company
(c) Hospital or institution: 6201 Pulaski Highway
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Richmond Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME John Godbee

3 (b) If veteran, name war: WWI #1
3 (c) Social Security Account No. 212-09-1182

4. Sex: M | 5. Color or race: W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Celeste Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13th 1895

8. AGE: Years: 50 | Months: 7 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Lewisville Ga.
(Town, county, and state)
10. Usual Occupation: Asst Treasurer & Genl Auditor
11. Industry or business: Davidson Transfer & Storage Co

FATHER
12. Name: John P. Godbee
13. Birthplace: Ga.

MOTHER
14. Maiden Name: Nora Willis
15. Birthplace: Ga.

16 (a) Informant: Celeste M. Godbee
(b) Address: 3302 Richmond Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 3/12/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~: U. S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1219 St. Paul St

19 MAR 11 1946 (Date rec'd by registrar) ~~Huntington~~ Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/46 19 , at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 3/8/46

VS 151

G38244

458977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38244

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 843 Hillman Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Thomas Hayes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Ellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-26-76

8. AGE: Years	Months	Days	If less than one day
69	4	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Night Watchman Chauffeur
11. Industry or business

FATHER
12. Name Martin Hayes.
13. Birthplace Md

MOTHER
14. Maiden Name ? ?
15. Birthplace Ireland

16 (a) Informant Reader
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory St Mary Emmanuel
Location Balto Md
18 (a) Funeral director Wilson Cook Inc
(b) Address 1314 Hollins St
19 (a) Filed March 14 1946 (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH March - 9 1946, at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1946, to March-9 1946, and that I last saw him alive on March 9 1946.

Immediate cause of death Pulmonary Tuberculosis, general advanced — Duration 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Medway
Address Johns Hopkins Hosp. Date signed 9 Mar

VS 150

G38245
JL - 89361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G38245
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -6 -20 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Ridgely St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Lottie Phillips

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1858

8. AGE: Years	Months	Days	If less than one day
87	6 4	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jesse Phillips
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Ann Shipley
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

MAR 11 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946; at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1944 to March 10 1946 and that I last saw her alive on March 10 1946

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerosis Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret McDonnell M. D.
Address B. C. H. Date signed 3/10/46

VS 150

correct age is especially important. Physicians: please write the

638246

BALTIMORE CITY HEALTH DEPARTMENT

TN. 99324 CERTIFICATE OF DEATH 157 (Registered No.) 638246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Boy Kofera (Gloria Jean

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16th 1946

8. AGE: Years | Months | Days: 11 | If less than one day: hr. min.

9. Birthplace Baltimore City Hospitals
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Kofera
13. Birthplace Mammoth Pa.

MOTHER
14. Maiden Name Gloria Jean ?
15. Birthplace Omaha, Neb.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) XXX XXXXX (b) Date thereof 3-2-46 (month) (day) (year)
(c) Cemetery or crematory XXXXXXX Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

19 MAR 11 1946 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27th 1946 19 at 8:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16th 19 46 to Feb. 27 19 46 and that I last saw him alive on Feb. 27 19 46

Immediate cause of death — Duration
Post-operative intestinal
Resection for gangrene of small bowel
Due to Congenital bands and volvulus
Due to
Other Conditions Prematurity
(Include pregnancy within 3 months of death)

Date of operation 2-22-46
Major findings of operation: Congen. bands, volvulus, gangrene small bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard A. Jones M. D.
Address Balto. City Hosp. Date signed 3-2-46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G38247 — BALTIMORE CITY HEALTH DEPARTMENT — G38247

CERTIFICATE OF DEATH 50

Registered No.

Please write the cause of death clearly and legibly. The correct age is especially important. Physicians: please write the information asked for carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution Md. Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltotety
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1457 Stevenson Pl
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IDA J. REESE (Ida Jeannette Reese)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife David Reese

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Oct-9-1870

8. AGE: Years 75 | Months 5 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Mr.? Caldwell

13. Birthplace Delawan

MOTHER 14. Maiden Name Daisy — ? —

15. Birthplace Delawan

16 (a) Informant Miss Amy E. Fischer (daughter)

(b) Address 1457 Stevenson Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Balto. - Md.

18 (a) Funeral director Stewart-Mann Co.

(b) Address 108 W. Mount Ave.

MAR 11 1946 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/ 1946 at 11 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1946 to 3/9 1946 and that I last saw HER alive on 3/9 1946

Immediate cause of death BRONCHO-PNEUMONIA — Duration 10 DAYS

Due to LUNG METASTASES

Due to CARCINOMA OF BREAST

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart Jr. M. D.

Address 1738 E. 28th St. Date signed 3/9/46

X

638248 638248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Classen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Freda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Latvia (town, county, or state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Latvia

MOTHER
14. Maiden Name unknown
15. Birthplace Latvia

16 (a) Informant Freda Frank
(b) Address 2712 Classen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-46 (month) (day) (year)
(c) Cemetery or crematory Beth Israel
Location Herring Run

18 (a) Funeral director Jack Lewis & Inc
(b) Address 1407 E Balto St

19 (a) MAR 11 1946 (b) Filed MAR 11 1946

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1946 to 3-10 1946 and that I last saw him alive on 3-10 1946

Immediate cause of death: Generalized arteriosclerosis. — Duration
Myocardial fibrosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin
Address Levindale Date signed 3/10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G38219 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland General Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert O. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. D

6 (b) Name of husband or wife

6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr.) Feb 13 1872

8. AGE: Years 73 34 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Md (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Lee
13. Birthplace Md.

MOTHER
14. Maiden Name Tonsey
15. Birthplace Md

16 (a) Informant Lee Lorraine
(b) Address 5-70 St. Mary's

17 (a) (Burial, cremation, or removal) (b) Date thereof Mar 14 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Adolphus Hubbard
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VR MAR 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12/46 19 at 8:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1946 to 3/12 1946 and that I last saw him alive on 3/12 1946

Immediate cause of death Generalized abd. peritonitis — Duration

Due to perforation of malignancy in sigmoid

Due to

Other Conditions Bilateral pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy 3/12/46 - Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Traynor M. D.
Address Md. Gen'l Hosp. Date signed 3/6/46

Burial Permit Issued Md

G38250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. I 4747

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 No. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 No. Eden St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Clarence Henry Burns

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Married

6 (b) Name of husband or wife Helena Burns
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 1895

8. AGE: Years	Months	Days	If less than one day
50	8		hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Thomas Burns
13. Birthplace Calvert Co Md.

MOTHER
14. Maiden Name Rebecca Chase
15. Birthplace Calvert Co Md.

16 (a) Informant Mary Rivers
(b) Address 1534 May Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Pennsylvania Ave.
19 (a) MAR 11 1946 (Registrar's signature) Registrar
(b) Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1946, to 3/10 1946, and that I last saw ~~him~~ alive on 3/10 1946

Immediate cause of death Broncho - Pneumonia — Duration 2

Due to -

Due to -

Other Conditions -

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operation: -
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at - M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury -

23. Signature Ronald Brightson M. D.
Address 571 Cherry Hill Rd. Date signed 3/10/46

X

638251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

638251
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave
(c) Hospital or institution:
Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry M. Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Grace Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27 1878

8. AGE: Years	Months	Days	If less than one day
67	4	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Printer Supplies
11. Industry or business Self

FATHER
12. Name Henry Lewis Martin
13. Birthplace Scotland

MOTHER
14. Maiden Name Helletta Monroe
15. Birthplace Va.

16 (a) Informant Mrs. William Davis
(b) Address 4305 Miami Pl.

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 MAR 11 1946 (Date filed) Huntington Willemin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1946, to March 8 1946, and that I last saw h alive on 19

Immediate cause of death Carcinoma of Lung — Duration 1 yr 3 mos

Due to

Due to

Other Conditions Metastasis to Lumbar Vertebra — Duration 2 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Briemyer M. D.
Address 2224 W. North Ave. Date signed 3/10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

VS. 150

G38252

G38252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Typewriter supplied. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1 MO

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 S Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edna Josenhans

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1946

8. AGE: Years	Months	Days	If less than one day
	1	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Roseline Josenhans
15. Birthplace Balt Md

16 (a) Informant Mrs Dominick Carrieri
(b) Address 223 S Calhoun St

17 (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 870 Fredrick Ave

18 (a) Funeral director Harry Hubike
(b) Address 1101 Edmondson Ave

19 (a) MAR 11 1946 (b) [illegible] for William A. Mull
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9 1946, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1946, to 3-9 1946, and that I last saw her alive on 3-9 1946.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Drake M. D.
Address Univ. Hospital Date signed 3-9-46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G38253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G382 3/10 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2567 W. Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2567 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine W. Schacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late George C. Schacher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1866.

8. AGE: Years 79 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Hartman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Charles Schacher
(b) Address 2567 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St

18 (a) Funeral director Harry H. Mitzfle
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1946 at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to March 8 1946.
and that I last saw her alive on March 7 1946

Immediate cause of death	Duration
Chronic Interstital Nephritis 2Yrs	
Due to	
Chronic Myocarditis	2Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Stelling M. D.
Address 2557 W. Mon Date signed 3/9/46

X

G38254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 G38254 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 McCabe Ave. City 12
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Barbara Lee Bosley.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1941

8. AGE: Years 4 | Months 2 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Balto, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Norman Bosley
13. Birthplace Maryland

MOTHER
14. Maiden Name Grace Gordon
15. Birthplace Maryland

16 (a) Informant Mother
(b) Address 744 McCabe Ave. City 12.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rest
Location Belair Rd.

18 (a) Funeral director John. A. McAdam
(b) Address 3000 E. Balto. St.

19 (a) (Date received by registrar) (b) Registrar

MAR 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9 1946, at 9 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1945 to Mar. 9 1946. and that I last saw h er alive on Mar. 8 1946.

Immediate cause of death Resp. Failure

Duration

Due to Increased Intracranial Pressure

Due to Pituitary Tumor.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan. 9, 1945

Major findings of operation: Tumor near Sella Turcica

of autopsy: Hydrocephalus, Sella turcica tumor

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George B. McAdam M. D.

Address Union Memorial Hosp Date signed 3-9-46.

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use

AB-9 638255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 F 638255

Registered No.

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos 12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N.Curley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Strohecker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15-1882

8. AGE: Years	Months	Days	If less than one day
63	4	25	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Strohecker (D
13. Birthplace Md.

MOTHER
14. Maiden Name Maude Cyrl (D
15. Birthplace Europe

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/12/46
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Rood.
Location Dolgir Rd.

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt. St

19 (a) (b)
(Date rec'd by registrar) (Registrar)

Huntington Hillsboro, Md.

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH March 8- 1946, at 10.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26- 1945 to 3-8 1946
and that I last saw her alive on 3-8- 1946

Immediate cause of death	Duration
CARCINOMA OF NASOPHARYNX	
With Multiple Metastasis	UNKNOWN
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth B. Nitterville M. D.
Address Baltimore City Hospitals Date signed 3-9-46

G38256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓159

Registered No. G38256

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5216 Cromarty Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Harman-A Alice Harman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. INFANT

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1946

8. AGE: Years | Months | Days 1 | If less than one day 2Y hr. min.

9. Birthplace Baltimore, Md. Univ. Hospital
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leonard C. Harman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice S. Eubank
15. Birthplace Virginia

16 (a) Informant Mr. Leonard C. Harman
(b) Address 5216 Cromarty Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Ramonean
(b) Address 4510 Liberty Heights Ave.

19 (a) MAR 11 1946 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9-46 1946 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1946 to 3-9 1946, and that I last saw he/she alive on 3-9 1946.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to ATELECTASIS

Due to PREMATURITY

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. B. Harman M.D.

Address Univ. Hosp. Date signed 3-9-46

X

G38257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G38257

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5216 Cromarty Rd.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Baby Girl Harman, B. Genevieve Harman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8 March 1946

8. AGE: Years — | Months — | Days +1/2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Leonard C. Harman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice S. Eubank
15. Birthplace Virginia

16 (a) Informant Mr. Leonard C. Harman
(b) Address 5216 Cromarty Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. [illegible]
(b) Address 4510 Liberty Heights Ave.

19 (a) MAR 11 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 March 1946, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6 1946 to 3-7 1946 and that I last saw h[illegible] alive on 3-8 1946

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 3-11-46

G38258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G38258 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4437 Clifton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4437 Clifton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver L. Tunis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Julia B. Tunis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1871

8. AGE: Years	Months	Days	If less than one day
74	5	14	hr. min.

9. Birthplace St. Michaels Md.
(Town, county, and state)
10. Usual Occupation Retired Elec Eng.
11. Industry or business

FATHER
12. Name Edwin L. Tunis
13. Birthplace Indiana

MOTHER
14. Maiden Name Ellen J. Wrightson
15. Birthplace St. Michaels Md.

16 (a) Informant Richard L. Tunis
(b) Address Ruxton Road Ruxton Md

17 (a) Burial (b) Date thereof Mar 13 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry A. Amacost
(b) Address 4204 Ridgewood Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-1946, at 5.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to 3-10 1946, and that I last saw him alive on 3-10 1946.

Immediate cause of death	Duration
Carcinoma of Larynx	3 yr
Due to	
Due to	
Other Conditions Senile Metabolism	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry H. Warren M. D.
Address 3604 Gamon Ave Date signed 3-11-46

G38259 | BALTIMORE CITY HEALTH DEPARTMENT | G38259
CERTIFICATE OF DEATH 46 E | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Primrose Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Primrose Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Jane Hale

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob Franklin Hale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9-1855

8. AGE: Years 90 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry Peregoy
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel Robbins
15. Birthplace Maryland

16 (a) Informant Harry E. Hale
(b) Address 4008 Primrose Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Received by registrar MAR 11 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8- 1946 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 Mar 8 19
and that I last saw h[illegible] alive on 3/8 1946.

Immediate cause of death: Intestinal Malignancy — Duration 2 yrs

Due to:

Due to:

Other Conditions Asteris - selerosis mitral regurgitation — Duration years

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 3902 Yeardley [illegible] Date signed 3/9/46

correct age is especially important. Physicians: please write the

VS 150

EMMA J. BALDWIN

G38260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Beech Ave (11)
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baldwin, Emma J.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Walter A. Baldwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10-1865

8. AGE: Years 80 Months 3 Days 29 If less than one day ___ hr. ___ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name Henry Whitelford
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza J. Marshall
15. Birthplace Maryland

16 (a) Informant Mrs. J. Floyd Cragbaugh
(b) Address 3712 Beech Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12-1946 (month) (day) (year)

(c) Cemetery or crematory St. Marys Hampden
Location Baltimore, Maryland

18 (a) Funeral director Burgie Funeral Home
(b) Address 3631 Falls Road

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MAR 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 9 - 1946, at 3 40' P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945, to 3-9 1946, and that I last saw h[illegible] alive on 3-9-1946.

Immediate cause of death Coronary Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Gangrene of Left Leg
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Krugman M. D.
Address Franklin Square Hosp. Date signed 3-9-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] information should be carefully supplied. The

LANDES

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G38661 G38661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3?
(c) Hospital or institution: Union Memorial Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Elm Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Lewis Landes

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-22-9179

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Ella Landes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1882

8. AGE: Years 63 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland, Carroll Co.
(Town, county, and state)

10. Usual Occupation Cares for street lights

11. Industry or business

FATHER
12. Name John Landes
13. Birthplace Carroll Co., Md

MOTHER
14. Maiden Name Mary Kinkle
15. Birthplace Md.

16 (a) Informant Mrs. Ella K. Landes
(b) Address 3710 Elm Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 2431 Fallis Road

19 (a) MAR 11 1946 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 2.09 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1946 to Mar. 10 1946 and that I last saw him alive on Mar. 10 1946

Immediate cause of death Peritonitis — Duration 24 days

Due to Ruptured appendix

Due to

Other Conditions Auricular fibrillation

(Include pregnancy within 3 months of death)

Date of operation Feb. 14, 1946

Major findings of operation: Ruptured appendix and peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Cameron Montgomery, Jr. M.D.
Address Union Memorial Hospital Date signed 3-10-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38262 — BALTIMORE CITY HEALTH DEPARTMENT — G38262 Registered No.

CERTIFICATE OF DEATH 43D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 S Highland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ... (b) County ...
(c) City or town ... (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Highland Ave (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Louis Conrad

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-9543

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice Conrad

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 30, 1879

8. AGE: Years 66 | Months 8 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Penny Dog

FATHER
12. Name John Conrad
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Markel
15. Birthplace Baltimore

16 (a) Informant Herbert E Martin
(b) Address 3602 Crossland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park
Location City

18 (a) Funeral director Merrick Funeral Home
(b) Address 2405 Gilsey St

19 (a) MAR 11 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1946, to March 9 1946, and that I last saw him alive on ... 19 ...

Immediate cause of death
Chronic Bronchitis
Chronic Myocarditis — Duration 25 yrs Jan 1946

Due to ...

Due to ...

Other Conditions Terminal Bronchial Pneumonia — Duration 1 day

(Include pregnancy within 3 months of death)

Date of operation ...
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature Harry LaChman MD
Address 2322 Callow Ave Date signed March 9 1946

correct age is especially important. Physicians: please write the

G38263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

G38263 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Elvaton (Millersville R.F.D) (If outside city or town limits, write RURAL and give town)
(d) Street No. Jumpers Hole Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Haslup

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	9	hr. min.

9. Birthplace Anne Arundel Co., MD. (Town, county, and state)

10. Usual Occupation
11. Industry or business None.

FATHER
12. Name Lloyd J. Haslup
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Frankel
15. Birthplace Pitta., Pa.

16 (a) Informant Mr. Wm. M. Dillon
(b) Address Elvaton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 13 (day) 46 (year)
(c) Cemetery or crematory Cedar Hill
Location Cedar Hill Brooklyn Md

18 (a) Funeral director T. F. Singleton
(b) Address Glen Burnie Md

19 (a) (b)
(Date received by registrar) MAR 11 1946 Hunter Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intracranial hemorrhage
Fractured pelvis

Other Conditions abdominal hemorrhage, ruptured aorta.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-10-46 at 7.30 P. M. a.a. Co.
(b) Where did injury occur Ritchie Highway near Pasadena Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Benedict Skotarelic M.D. (Medical Examiner)
Date signed March 11, 1946

G38264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

VS 1B

Registered No. G38264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Esplanade Apts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Eastern Ave & Brooklandville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sigmund Jr. Adler

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cora E. Adler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 - 1874

8. AGE: Years 71 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Shoe Business

11. Industry or business

FATHER
12. Name Solomon Adler
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs C. E. Adler
(b) Address Esplanade Apts

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mch 12/46 (month) (day) (year)

(c) Cemetery or crematory Balto Hebrew
Location Baltimore

18 (a) Funeral director Dan Rondleman & Son
(b) Address 1902 Eutaw Place, Huntington Williams, Mgr

19 MAR 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 10 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Mch 10 1946, and that I last saw him alive on Mch 10 1946;

Immediate cause of death Carcinoma of Bladder — Duration 1 year

Due to Carcinoma of Prostate — 1 1/2 yrs

Due to

Other Conditions Leucocytosis — 5 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Yeager

Address The Esplanade Date signed 3/10/46 D

VS 150

ERNIN A MAYER

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38265 HEALTH DEPARTMENT—CITY OF BALTIMORE G38265

CERTIFICATE OF DEATH P3a

1. PLACE OF DEATH

Registered No.....

CITY OF BALTIMORE: (No.....St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred.....yrs.....mos.1.....da. How long in U. S. If of foreign birth?.....yrs.....mos.....da.

2. FULL NAME THOMAS F. OCONNOR

If U. S. Veteran specify WAR.....

(a) Residence: No. 841 S. ELLWOOD AVE. St., ...Ward.....

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of LAURA V. OCONNOR

6. DATE OF BIRTH (month, day, year) JUNE 14 1872

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	8	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. TELEGRAPHER

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (city or town) (State or country) BALTIMORE MD.

FATHER

13. NAME HUGH OCONNOR

14. BIRTHPLACE (city or town) (State or country) IRELAND

MOTHER

15. MAIDEN NAME ANN KENNY

16. BIRTHPLACE (city or town) (State or country) IRELAND

17. INFORMANT LAURA V. OCONNOR (WIFE)
(Address) 841 S. ELLWOOD AVE.

18. BURIAL, CREMATION, OR REMOVAL
Place NEW CATHEDRAL Date MAR. 12/46

19. UNDERTAKER Leilich Zeiler Inc.
(Address) 403 S. WOLFE ST.

20. MAR 11 1946 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) MARCH 10, 1946

22. I HEREBY CERTIFY, That I attended deceased from 15 FEBRUARY, 1946, to 10 MARCH, 1946

I last saw h/M. alive on 9 MARCH, 1946 Death is said to have occurred on the date stated above, at 8 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
ARTERIOSCLEROSIS	1936
PNEUMONIA BRONCHO	1 FEB. 46
CEREBRAL HEMORRHAGE	9 MARCH 46
Other contributory causes of importance:	

Was an operation performed? NO Date of.....

For what disease or injury?.....

Name of operation.....

What test confirmed diagnosis?.....Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?.....Date of injury.....19....

Where did injury occur? NONE
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
NO If so, specify.....

(Signed) Benjamin Wigtertein M. D.

(Address) 121 S. HIGHLAND AVE.

OCCUPATION is very important. See instructions on back of certificate.

V8 3

1

G38266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G38266
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Information to be supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 71
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 E Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-37

8. AGE: Years 8 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Edward Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Alfreda Brooks
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 11 46 (month) (day) (year)

(c) Cemetery or crematory
Location Richmond, Va

18 (a) Funeral director Mrs. Robert G Elliott
(b) Address 1129 N. Caroline St.

19 (a) MAR 11 1946 (Date rec'd by Registrar) (b) Huntington W. Va. M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946 at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to Mar 9 1946 and that I last saw h alive on Mar 9 1946

Immediate cause of death Respiratory failure — Duration 20 min

Due to Subphrenic abscess

Due to Ruptured appendix

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-9-46

Major findings of operation No operation could be done

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Hopkins
Address Johns Hopkins Hosp Date signed 3-9-46 M. D.

G38267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√6

G38267 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1153 W. Mount (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizah Sutton √

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1941

8. AGE: Years	Months	Days	If less than one day
5		19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation child -
11. Industry or business

FATHER
12. Name Elizah Sutton, Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Johnson
15. Birthplace Md.

16 (a) Informant Anna M. Sutton
(b) Address 1153 W. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Fulton Ave. Mrs. Katie R. Williams, Mgr.

19 MAR 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1946, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1946, to 3-7 1946 and that I last saw h alive on 3-7 1946

Immediate cause of death Waterhouse Friderichsen syndrome — Duration 12 hrs.
Due to Meningococcemia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy Hemorrhage in adrenals

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles L. Butler M. D.
Address Univ. Hospital Date signed 3-7-46

VS 150

correct age is especially important. Physicians: please write the

C38268
CWK-74579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82

C38268
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 8- 27
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Bonson Street
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd Walker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife Maggie Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1881

8. AGE: Years	Months	Days	If less than one day
65	?	?	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Walker
13. Birthplace Virginia

MOTHER
14. Maiden Name Sally ?
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 11 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946; at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1942 to March 7 1946 and that I last saw h. in alive on Mar. 7 1946.

Immediate cause of death	Duration
? Arteriosclerosis Lateral Sclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy Not reported yet

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature I. P. Gerwigor M. D.
Address Baltimore City Hosp. Date signed 3-8-46

VS 150

Dorsey

638269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156a

Registered No. 638269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 8th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Sawn Vieew ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie Dorsey

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Mr. William Dorsey
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
52	5	18	hr. min.

Sept 30-1793

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Charles A. Martens
13. Birthplace Va.

MOTHER
14. Maiden Name Mrs. Louise Kanij
15. Birthplace Ky.

16 (a) Informant Mr. William Dorsey
(b) Address 3205 Sawn Vieew ave

17 (a) Burial (b) Date thereof Mar 13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director Jos. D. Stewart & Son
(b) Address 3701 Kentucky ave

19 MAR 11 1946 (by) Huntington Millington, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/46 19 , at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21/46 19 , to 3/9/46 19 , and that I last saw her alive on 3/9/46 19

Immediate cause of death Respiratory Failure due to Cancer — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/24/46

Major findings of operation: Tumor of uterus & ovarian.

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Bailey M. D.
Address Mercy Hosp. Date signed 3/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38270 BALTIMORE CITY HEALTH DEPARTMENT G38270

CERTIFICATE OF DEATH 1706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution Smith Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mich Rd.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ignatius John Potocki

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Gladys M. Potocki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1900

8. AGE: Years	Months	Days	If less than one day
45	4	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Miller
11. Industry or business Baltimore News Post
FATHER 12. Name Stanislaus Potocki
13. Birthplace Poland
MOTHER 14. Maiden Name Veronica —
15. Birthplace Poland
16 (a) Informant Gladys M. Potocki
(b) Address Pasadena, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Wesburg
Location Baltimore Co.
18 (a) Funeral director Roland L. Fiske
(b) Address 2112 Dundalk Ave.
MAR 11 1946 (b) Huntington Williams, M.D. Registrar
Date received by Local Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March [illegible] 1946, at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 8, 1946 7:45 A.M.
(b) Where did injury occur Lipin Corner.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No.
(d) Means of injury Auto accident. was inj

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 3-8-46

G38271

488160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38271

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hortense Taylor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female.

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-1926.

8. AGE: Years 20 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation School.

11. Industry or business

FATHER
12. Name Frank Taylor.
13. Birthplace Va.

MOTHER
14. Maiden Name Ida Crawley.
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kilmarnock
Location Kilmarnock Va

18 (a) Funeral director Geo. S. Keiser
(b) Address 1303 Pressstman St

19 (a) (b)
(Date could be registered) Registrar

MAR 11 1946 Huntington Williams, MD

VS-150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March - 9 1946 at 3.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9. 1946. to March - 9 1946. and that I last saw h er alive on March - 9 1946.

Immediate cause of death: Tuberculosis Generalized involving Lungs, Pleurae, Brain, Abdominal and Pelvic Viscera — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Autopsy Tuberculosis of Lungs, Pleurae, Peritoneum, Abd. & Pelvic Viscera.

of autopsy: The chief of Rt cerebral hemisph

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Freeman D Stephen M. D.

Address Johns Hopkins Hospital Date signed 3-9-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL 638672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

638672 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Spaulding Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Stocksdale

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	217-14-5566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1873

8. AGE: Years	Months	Days	If less than one day
72	7	25	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Western National Bank

FATHER
12. Name Noah Stocksdale
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Gittings
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

MAR 11 1946
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946 at 6:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1945 to Mar. 9 1946, and that I last saw him alive on Mar. 9 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Rowland M. D.
Address B. C. H. Date signed 3/9/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38273 / 124B / G38643

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 S. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE DeHAVEN

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Franklin T. DeHaven
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 22, 1899
8. AGE: Years 47 | Months 1 | Days 16 17 | If less than one day ... hr. ... min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James H. Preston
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Annie Higgins
(b) Address 1801 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 11 1946 (b) (Date rec'd by registrar) Registrar

VS 13c

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 8, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to 3/8 1946. and that I last saw her alive on 3/8 1946.

Immediate cause of death	Duration
Cirrhosis of Liver	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2020 Wilkens ave Date signed 3/9/46

Huntington Williams, Md.

G38474 G38474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2801 Kildaire Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Kildaire Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George M Hadaway

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Widower

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 1864

8. AGE: Years 85 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Kent Co Md (Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business Gen Store

FATHER 12. Name Geo W

13. Birthplace Md

MOTHER 14. Maiden Name Mary Ashley

15. Birthplace Md

16 (a) Informant Mrs Elsie L Brogue

(b) Address 2801 Kildaire Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/46 (month) (day) (year)

(c) Cemetery or crematory Chestertown Cem

Location Chestertown Kent Co Md

18 (a) Funeral director Edward Fowler

(b) Address 2819 West Blvd

19 (a) (Signature of local registrar) (b) Huntington Williams Registrar

MAR 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10 1946, at 2.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Mar 10 1946, and that I last saw h[illegible] alive on Mar 4 1946.

Immediate cause of death: 1 Cardio-respiratory failure

Due to: General arteriosclerosis

Due to:

Other Conditions: Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Date of operation March Feb 13 1941

Major findings of operation: Benign prostatic hypertrophy

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Franklin E Foote M. D.

Address 1115 N Eutaw Date signed 3-11-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38275 ✓ G38275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

G38275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 E. 25 St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 E. 25 St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Strobel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

~~4. Sex~~ | 5. Color or race | 6 (a) Single, married, widowed, or divorced
Female | White | Widow

6 (b) Name of husband or wife William Strobel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 6. 1866

8. AGE: Years 79 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Earl Stockhausen
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Edith A. Powe
(b) Address 1613 E. 25th St

17 (a) Burial (b) Date thereof Mar 12 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mrs. Nus John M. Trufel & Son
(b) Address 801 W. Lafayette Ave

19 (a) (Date paid by registrar) (b) Huntington Williams, M.D. Registrar

MAR 11 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Mar 9 1946
and that I last saw h[illegible] alive on Mar 9 1946

Immediate cause of death: Cerebral hemorrhage — Duration 1/2 hr.

Due to Cerebral Arterio sclerosis

Due to

Other Conditions Parkinson's Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

10 Jr
PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Branger

Address 1402 E. Lanvale Date signed 3-9-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38276 ✓ G38276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilkins + Caton Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yr 6 mo 9 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 W. Lee Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Carmelita Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1869

8. AGE: Years 77 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Sister

11. Industry or business

FATHER
12. Name Thomas Campbell
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigid Crane
15. Birthplace Ireland

16 (a) Informant Hospital Record
(b) Address Caton + Wilkins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey + Sons
(b) Address 1827 W. North Ave.

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

MAR 11 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 10:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1946 to March 10 1946 and that I last saw him alive on March 10 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Cardiac Vascular disease	
Due to	
Other Conditions Carcinoma	

N Carcinoma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Reinhardt, Jr. M. D.
Address St Agnes Hosp Date signed 3/10/46

X

G38277 X V G38277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7612 Old Battle Grove Rd (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) **FULL NAME** Baby Boy Kropp

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex M B | 5. Color or race W W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-11-46

8. AGE: Years — | Months — | Days — | If less than one day One hr. five min.

9. Birthplace Maryland Gen. Hospital (Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER 12. Name Wally Kropp
13. Birthplace Balto Md

MOTHER 14. Maiden Name Jean Kieffer
15. Birthplace Pike Grove Pa.

16 (a) Informant Wally Kropp
(b) Address 7612 Old Battle Grove Rd

17. (a) Burial (b) Date thereof 3-12-46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John J. Mulloy Jr
(b) Address 2435 E Oliver St

19 (a) ..... (Date rec'd by) Washington Williams, M Registrar

MAR 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-46 19 ..., at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11-46 19 ..., to Same 19 ..., and that I last saw him alive on 3-11-46 19 ...

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity (6 mo.)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: .....
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)*
(e) Means of injury .....

23. Signature John F. Noguera M. D.
Address Md Gen Hosp Date signed 3-11-46

correct age is especially important. Physicians: please write the

G38278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56

Registered No. G38478

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Devonshire Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Gertrude F. Brooks

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Daniel F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1877

8. AGE: Years 68 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John C. Middlekauff
13. Birthplace: Va.

MOTHER
14. Maiden Name: Gertrude F. McFaul
15. Birthplace: Balto. Md.

16 (a) Informant: Robert Lee Brooks
(b) Address: 3510 Devonshire Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~: David Ridge
Location: Pikesville Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 2412 St. Paul St.

19 (a) (Date rec'd by registrar) MAR 12 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1946, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1946, to 3/9 1946, and that I last saw her alive on 3/9 1946

Immediate cause of death: Respiratory failure during

~~Due to~~ Operation for spinal cord in cervical region for tumor

Due to:

Other Conditions: Paralysis - total - below neck

(Include pregnancy within 3 months of death)

Date of operation 3/9

Major findings of operation: Tumor of Cervical portion of spinal cord

of autopsy: Gauel

Duration

(see page over)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Gerard S. Brown M.D

Address: Md. General Hospital Date signed 3/9/46

correct age is especially important. Physicians: please write the

VS 150

G38279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G38279 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4110 Orchard Ave Brooklyn
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Brooklyn
(d) Street No. 4110 Orchard Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac H. Walker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1875

8. AGE: Years 71 | Months 0 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Laborer

FATHER
12. Name Unknown Walker
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Fearn Sweeney
(b) Address 4110 Orchard Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross A.A. Co
Location A.A. Co. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St.

19 MAR 12 1946 Huntingtown Williamsport Md
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1946, 1 hr. 45 m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945 to March 10 1946 and that I last saw him alive on 3/9 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 5 mos.
Due to Arterio-Sclerotic Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Lubin M.D.
Address 320 Cathedral (Date signed) 3/11/46

Paul Lubin

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 Charter Oak Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Charter Oak Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F. Hanson

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mary E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1862

8. AGE: Years	Months	Days	If less than one day
83	4	21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state or foreign country)
10. Usual Occupation Manager Sup Cutting
11. Industry or business Army Supplies

FATHER
12. Name Elias Hanson
13. Birthplace Md

MOTHER
14. Maiden Name Lona Morney
15. Birthplace Md

16 (a) Informant Mrs Olive Compton
(b) Address 411 Charter Oak Ave

17 (a) Final (b) Date thereof 3/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Pallorra & Co Inc
(b) Address 1217 E Lombard Street Baltimore, Md

19 MAR 12 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946, at 10 34 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1946, to March 11 1946, and that I last saw h~~im~~ alive on March 9 1946

Immediate cause of death	Duration
Cerebral Apoplexy	6 days
Due to Hypertension & Arteriosclerosis	
Due to Chronic nephritis	Years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Burnard Ford M. D.
Address 2200 Garrison Blvd Date signed 3/11/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38281

BALTIMORE CITY HEALTH DEPARTMENT 93D

CERTIFICATE OF DEATH

Registered No. G38281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2596 W. Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES V. WALLACE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Married

6 (b) Name of husband or wife Louise Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th 1886

8. AGE: Years	Months	Days	If less than one day
59	8	7	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Chambers Decorating Co.

FATHER
12. Name Edward J. Wallace
13. Birthplace Md

MOTHER
14. Maiden Name Annie McShane
15. Birthplace Md.

16 (a) Informant Louise E. Wallace
(b) Address 2596 W. Fayette St.

17 (a) Burial (b) Date thereof 3/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 MAR 12 1946 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11/46 19..., at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weaver M.D.
Medical Examiner.
Date signed 3/11/46

G38282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38282 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Alto Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Alto Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta B. Springer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Dr. Nathan A. Springer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1881

8. AGE: Years 65 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name George W. Bennett
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katie A. Messenberg
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. G. Burnett Webster
(b) Address Rochester, N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Williams, M.D.

MAR 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946, at 9:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945 to Mch 9 1946 and that I last saw h alive on Mch 9 1945

Immediate cause of death: Cerebral Apoplexy — Duration: 1 wk.

Due to: Hypertension — Duration:

Due to: Diabetes Mellitus — Duration:

Other Conditions: Arteriosclerosis — Duration: many yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Burnett Wood M. D.
Address 2200 Garrison Blvd. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G38283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2038 Edmondson Ave.
(c) Hospital or institution:
16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ***

3 (a) FULL NAME Margaret M. Schmuck

3 (b) If veteran, name war ***

3 (c) Social Security Account No. ***

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Fredrick W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1878

8. AGE: Years 67 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Louise Brady
(b) Address 2038 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (b)
MAR 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946 at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11 1946 to 3-11 1946, and that I last saw h[illegible] alive on 3-11 1946

Immediate cause of death	Duration
generalized carcinomatosis of peritoneum with perf.	6 hours
Due to spontan. perforation	
Due to Carcinoma of rectum (one year duration)	1 Year
Other Conditions –	

(Include pregnancy within 3 months of death)
Date of operation Radium - May 1945
Major findings of operation: Ca of rectum
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – (Specify type of place) While at work? –
(e) Means of injury –

23. Signature H. W. Scheye
H. W. SCHEYE, M. D.
Address 2021 EDMONDSON AVE. Date signed 3/11/46
BALTIMORE-29, MD.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38284 ✓ G38284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 832 Tessier St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 Tessier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnnie Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul. 1894

8. AGE: Years 51 | Months 8 | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name —
13. Birthplace N. C.

MOTHER
14. Maiden Name —
15. Birthplace N. C.

16 (a) Informant Ruth Blackwell
(b) Address 832 Tessier St.

17 (a) Burial (b) Date thereof 3-14-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b)

MAR 12 1946

Hunting for Hillsboro, M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 4 1946 to Mar 9 1946 and that I last saw h— alive on Mar 9 1946

Immediate cause of death: Lobar Pneumonia — Duration: 10 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Pettigrew M. D.

Address 817 Hamilton Ter. Date signed Mar 11/46

X

correct age is especially important. Physicians: please write th

638285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

638285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 1/2
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 407 N. Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie Bush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Rockie Point N. C. (Town, county, and state)

10. Usual Occupation Domestic.

11. Industry or business

FATHER
12. Name Hesse Moore
13. Birthplace N. C

MOTHER
14. Maiden Name Julia Bunton
15. Birthplace N. C.

16 (a) Informant Mammie Mitchell
(b) Address 1707 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. F. Co. md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Mount St

19 MAR 12 1946 Registered by Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1946, at 9 45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 1st, 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 19/1

(a) Date of injury 3/9/46 at 9 A. M.
(b) Where did injury occur? 407 N. Vincent St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Clothes became ignited on stove.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 3-9-46

G38286 ✓ G38286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 Argonne Drive
(c) Hospital or institution: none 9+
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Argonne Drive (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert B. Avery

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Cora M. Maxim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 27, 1874

8. AGE: Years	Months	Days	If less than one day
71	10	11 13	hr. min.

9. Birthplace Nevada (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business Anaconda Co.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Eugene A. Avery
(b) Address 918 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory
Location Anaconda, Mont.

18 (a) Funeral director John A. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 MAR 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1945 to March 10 1946 and that I last saw h/M alive on March 10 1946.

Immediate cause of death	Duration
Malnutrition -	2 YRS -
Starvation -	
Due to Senile Dementia -	2 YRS -
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward Harrigan M.D.
Address 5217 York Road Date signed 3-12-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G38287

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Any physician who refuses or neglects to comply with the provisions of this law shall be guilty of a misdemeanor and subject to a fine of not less than $10 nor more than $100.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 E. Lake Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 E. Lake Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE K. LINK

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Link
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1865

8. AGE: Years	Months	Days	If less than one day
81	2	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fred William Flentje
13. Birthplace Hanover, Germany

MOTHER
14. Maiden Name Richards
15. Birthplace Germany

16 (a) Informant Dr. Amelia E. Link (daughter)
(b) Address 2211 E. Lake Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAR 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 9, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to Mar. 9 1946, and that I last saw h.er alive on Mar. 9 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	2 mos.
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt. B. Wright M. D.
Address Masonic Auth. Bldg. Date signed 3/12/46

X

G38288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G38288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 5/1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owen Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife ~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-1898

8. AGE: Years	Months	Days	If less than one day
48	-	28	hr. min.

9. Birthplace Northumberland Co. Va.
(Town, county and state)

10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Robert Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Va

16 (a) Informant Every Taylor Dorsey
(b) Address 621 N. Mount St.

17 (a) Burial (b) Date thereof 3/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bright Play ave

19 MAR 12 1946
(Date received by local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946, at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism: Fractured Neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 1st 1946 5/1 M.
(b) Where did injury occur? 117 Eden ST
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Fall downstairs

23. Signature Robert E. Fontaine M.D.
Medical Examiner.
Date signed March 8 1946

G38689 BALTIMORE CITY HEALTH DEPARTMENT G38689

CERTIFICATE OF DEATH 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 871 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 871 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS THORNTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jacob Thornton
13. Birthplace Md,

MOTHER
14. Maiden Name Mary Garrett
15. Birthplace Md.

16 (a) Informant Mrs. Vivian James
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 7 1946, to March 10 1946, and that I last saw h alive on 19

Immediate cause of death Lobar Pneumonia — Duration 2 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Pettiford M. D.
617 Hamilton Ave Date signed March 11/46

Huntington Williams Md

VS 150

MAR 12 1946

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-[illegible] 638290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 3B

✓ G38290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos- 15days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Christopher Hughes

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Mary A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13- 1876

8. AGE: Years 70 | Months 0 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Md. BALTO. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name John Hughes
13. Birthplace Md.

MOTHER
14. Maiden Name Sara Leon
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 13/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeller Inc.
(b) Address 403 S. WOLFE ST.

19 (a) ... (Date rec'd by registrar) (b) Lington Williams, M.D. Registrar

MAR 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8- 1946, at 11PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23- 1946 to 3-8- 1946 and that I last saw him alive on 3-8- 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	2yrs
Due to	
Due to	
Other Conditions acute intestinal obstruction-ruled.	

(Include pregnancy within 3 months of death)

Date of operation 2-21-46
Major findings of operation: Impacted indurated inflamed tumor
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hospitals Date signed 3-9-46

correct age is especially important. Physicians: please write the

X

G38291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH #20

Registered No. G38291

Please answer questions in ink. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2-3
(e) Length of stay in Baltimore (yrs., mos., or days): 20 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1722 Aliceann St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Hill, Arthur Ernest

3 (b) If veteran, name war:
3 (c) Social Security Account No.: 086-12-0602

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1892

8. AGE: Years	Months	Days	If less than one day
53	2	26	hr. min.

9. Birthplace: ? Germany (Town, county, and state)
10. Usual Occupation: Messman
11. Industry or business: Seafarer

FATHER
12. Name: Andrew Hill
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louise Korpis
15. Birthplace: Germany

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 12/46 (month) (day) (year)
(c) Cemetery or crematory: ST. JOHNS
Location: ELLIOTT CITY MD.

18 (a) Funeral director: Leilly & Zeiten inc.
(b) Address: 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 8 1946, at 10:38 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1945 to Mar. 8 1946 and that I last saw h im alive on Mar. 8 1946.

Immediate cause of death	Duration
Carcinoma of left lung with metastases	UNKNOWN
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 3/11/46
US Marine Hospital, Balto, Md.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38232

CERTIFICATE OF DEATH 13B

G38232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 S. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 S. Washington Str., (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary (Mamie) Nickum

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.:
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Alonzo Nickum
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) OCT. 17 1876
8. AGE: Years 69 | Months 4 | Days 21 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business Lord Balto. Hotel

FATHER
12. Name JAMES AFFAYROUX
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name MARY COURTNEY
15. Birthplace BALTO.MD.

16 (a) Informant MRS? SEIGMUND (NEICE)
(b) Address 207 S.WASHINGTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR.14/46 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Leibly & Zeiler Inc.
(b) Address 403 S.WOLFE ST.

19 (a) MAR 12 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH MAR. 10 1946, at 8/30

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1946 to March 10 1946, and that I last saw h-- alive on March 10 1946.

Immediate cause of death	Duration
Chronic nephritis	
Due to Uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. Kadan M. D.
Address 2306 Eutaw Pl Date signed 3-11-46

X

Entries must be typewritten or printed in black ink. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Please write plainly in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94-A

Registered No. 638293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 N. Bellenger
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Bellenger 4
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Novak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Novak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1858

8. AGE: Years: 88 | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Wiegent
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edward F. Perotka
(b) Address 2 E. Beach Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore

18 (a) Funeral director Trump Lerach & Son
(b) Address 900 N. Chester St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS-180 MAR 1 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1946 to 3/11 1946, and that I last saw h.e.r. alive on 3/11 1946

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Generalized Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pekarny M. D.
Address 2200 E. Madison St. Date signed 3/12/46

X

G38294 HEALTH DEPARTMENT—CITY OF BALTIMORE G38294

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Shields Place Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Frank W. Sr. 14-2 If U. S. Veteran specify WAR

(a) Residence: No. 1427 Shields St., 14 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	col	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Aug 6 - 1898

7. AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	48	-	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) S. C

FATHER

13. NAME —

14. BIRTHPLACE (city or town) (State or country) —

MOTHER

15. MAIDEN NAME —

16. BIRTHPLACE (city or town) (State or country) —

17. INFORMANT Ruth W. Sr. (Address) 1427 Shields Place

18. BURIAL, CREMATION, OR REMOVAL. Place Burial Mt Auburn, Date 3-13- 1946

19. UNDERTAKER George D. Nelson (Address) 1303 Pressman St Washington 17, D. C.

20. MAR 12 1946 Washington 17, D. C. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3-10 1946

22. I HEREBY CERTIFY, That I attended deceased from 12-11 1945 to 3-10 1946

I last saw him alive on 3-10 1946 Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	

Other contributory causes of importance: Hypertensive Card D. Walnut Road Chevy

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) M Earline M. D.

(Address) 883 Park Ave

OCCUPATION is very important. See instructions on back of certificate.

G38295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G38295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 m 2 m
(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Cumel St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years (1) 90 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Texas Co. Texas (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Prov. Hosp.
(b) Address Unable to obtain

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 12 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1946 at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1943 to 2-18 1946 and that I last saw him alive on 2-18 1946.

	Duration
Immediate cause of death Acute Congestive failure	
Due to Hypertensive Cardiovascular renal disease	
Due to	
Other Conditions Rt Hemiplegia Bronchogenic Carcinoma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E. Wadkins M.D.
Address 861 Harlem Ave Date signed 3/7/46

3360 E. 93d Woodland

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(38296)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

638296

Registered No.

Write the causes of death clearly and legibly. Use only regular, unabbreviated, nontechnical terms; please write the cause of death in plain English.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) since 10/10/44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Hilldercy St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Kessinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
87	—	—	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School

18 (a) Funeral director
(b) Address

MAR 12 1946
(Date rec'd by registrar)

Commissioner of Health

(b) Huntington Williams M.D.
Registrar

VS 151

3561

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1946, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to Arteriosclerotic CV disease

Other Conditions Fractured left hip

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 2/20/46 about 3:20 P.M. 7/1
(b) Where did injury occur? 3123 Hilldercy St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Fell out of chair

23. Signature C. P. Puleniski M.D.
Medical Examiner.
Date signed 2/27/46

X

G38697

BALTIMORE CITY HEALTH DEPARTMENT ✓ 47D G38697

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1352 Homestead St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1352 Homestead St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry F. Brooks

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1887

8. AGE: Years 58 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Mason
11. Industry or business

FATHER
12. Name Shadrick Brooks
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie Dowell
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Lee Brooks
(b) Address 1352 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 13/46 (month) (day) (year)
(c) Cemetery or crematory Dolphy Recreation
Location 4700 Bedford Rd.

18 (a) Funeral director Elmer W. Coulbourn & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) MAR 12 1946 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 9th 1946, at 5:?? P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Mar. 9 1946 and that I last saw him alive on Mar. 8 1946

Immediate cause: Intestinal obstruction — Duration 48 hrs.
Due to Carcinoma of Lung. — 2 yrs.
Due to Arter. Sclerosis & Disease — Unknown
Other Conditions Arteriosclerosis — Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature William F. Linton, M. D.
Address 2824 St. Paul St. Date signed 3/12/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

250443
G38298

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38298

CERTIFICATE OF DEATH 46H Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 N. Calhoun Pl (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH K. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Married

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-4-84

8. AGE: Years	Months	Days	If less than one day
61	11	6	hr. min.

9. Birthplace N. Carolina. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Jos. Briscoe
13. Birthplace N. Carolina.

MOTHER
14. Maiden Name Alice Thompson
15. Birthplace N. Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) MAR 14 1946 (b) Hunter Williams, M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Mar. 10 1946 at 4 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1946 to Mar. 10 1946 and that I last saw h-w alive on Mar. 10 1946

Immediate cause of death Pulmonary Embolus

Due to ? Thrombosis Femoral Veins

Due to

Other Conditions Rheumatic Heart Dis. Retroperitoneal Sarcoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theron F. Clapham M. D.
Address Johns Hopkins Hospital Date signed 3-10-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38299

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38[illegible]

CERTIFICATE OF DEATH 831

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Madison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Marshall

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Thomas R. Marshall
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 11, 1894

8. AGE: Years	Months	Days	If less than one day
51	10	29	hr. min.

9. Birthplace Baltimore (17) Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Joseph Collins
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Amanda Bedford
15. Birthplace Baltimore Md

16 (a) Informant Mr Thomas R. Marshall
(b) Address 2502 Madison Ave.

17 (a) Burial (b) Date thereof 3-14-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Thos. Geo W. Hulland
(b) Address 1631 Druid Hill Ave

MAR 12 1946 (b)
(Date rec'd by Registrar) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941 to March 1946 and that I last saw her alive on March 9 1946

Immediate cause of death	Duration
Cerebral Hemorrhage (Massive)	
Due to Hypertension	6 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert L. Townsley Jr
Address 2024 Madison Ave Date signed 3/11/46

X Moseley

VS 150

correct age is especially important. Physicians: please write the

G38300 BALTIMORE CITY HEALTH DEPARTMENT G38300 Registered No.

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 N. Gilmor Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Gilmor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD HAYES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widow

6 (b) Name of husband or wife Hattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 6, 1861

8. AGE: Years	Months	Days	If less than one day
85	6	7	hr. min.

9. Birthplace New Kent, Va. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business

FATHER
12. Name Washington Hayes
13. Birthplace Va.

MOTHER
14. Maiden Name Uknown
15. Birthplace

16 (a) Informant Lucy Upton
(b) Address 1613 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Membrial Pk
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1611 Druid Hill Ave.

19 (a) MAR 12 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946 at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to Mar 9 1946, and that I last saw h[illegible] alive on Mar 9 1946.

Immediate cause of death: Uremia — Duration: 1 wk
Due to: Arteriosclerosis
Due to: Heart Disease
Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. W. Deckelman Jr.
Address 421 N. Johnson Date signed 3/12/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rohoffl G38301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107 G38301 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(a) Street No. 2125 Druid Hill Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alfred A Rohoffl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Henrietta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21 1860

8. AGE: Years 85 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace British West Indies (Town, county, and state)

10. Usual Occupation Clerk.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary M. Bradford
(b) Address 1703 Fitzwater St. Phila, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-1946 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Thos. E. Stafford
(b) Address 1631 Druid Hill Ave.

19 (a) MAR 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/1946 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1945 to 3/9 1946 and that I last saw him alive on 3/6 1946

Immediate cause of death	Duration
Bronchial Pneumonia	
Due to Acute Chole[illegible]	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben R Lentz M. D.
Address 2134 Druid Hill Ave Date signed 3/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

638302

AB-75540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

638302

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs- 7mos-25days
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Myrtle Ave.
1624 W Lafayette (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Floyd

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Ella Belle (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22- 1872

8. AGE: Years	Months	Days	If less than one day
73	2	17	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Easley Floyd (D
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Wheeler
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3 13 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A, G Md

18 (a) Funeral director Sarah D Brown Dr
(b) Address 1056 Monty Mary St

19 (a) MAR 12 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9- 1946 at 2 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14- 1942 to 3-9 1946
and that I last saw h im alive on 3-9- 1946

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address Md Date signed 3/9/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38303

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 Mosher.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 1403 Mosher (If rural, give location)
(e) Citizen of foreign country? Was (Yes or No)
If yes, name country Jamaica

3 (a) FULL NAME Cornelius A. Jackson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13-1888

8. AGE: Years 57 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Westmoreland Jamaica (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Saw Office

FATHER
12. Name unknown
13. Birthplace Jamaica

MOTHER
14. Maiden Name unknown
15. Birthplace Jamaica.

16 (a) Informant Alice Jackson
(b) Address 1403 Mosher

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13, 1946 (month) (day) (year)

(c) Cemetery or crematory
Location Town Neck Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.
(b) Huntington Williams MD

MAR 12 1946

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to March 9 1946 and that I last saw h[illegible] alive on March 9-1946

Immediate cause of death Chronic Myocarditis — Duration 3 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. C. Smith

Address North Ave & Druid Hill Ave Date signed Mar 9 46

G38304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G38304

write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Matthews Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1925

8. AGE: Years	Months	Days	If less than one day
20	7	5	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Spencer Carter
13. Birthplace Yorkstown, Va.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Richmond Va.

16 (a) Informant Mr. Matthews Jenkins
(b) Address

17 (a) Burial (b) Date thereof March 12, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St. Huntington Williams

19 MAR 12 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 48

20. DATE OF DEATH March 10, 1946, at 8 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from; natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation (choking)

Due to
Contusions of abdomen with intra abdominal hemorrhage.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at M.
(b) Where did injury occur? Body found 1600 Druid Hill Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Not determined While at work? No
(d) Means of injury Choked and beaten

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 3-11-46

VS 151

G38505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1492

Registered No. G38505

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 W. Randall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 W. Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna K. Germershausen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. J. Germershausen
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Oct. 17 - 1885

8. AGE: Years 60 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Bernhard Filach
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Pfeffer
15. Birthplace Germany

16 (a) Informant Wm. J. Germershausen
(b) Address 111 W. Randall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-1946 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ London Park
Location 3201 Frederick Ave.

18 (a) Funeral director Elizabeth Clark Funeral Home
(b) Address 115 E. West St.

19 (a) (b)

Filed and recorded by registrar MAR 12 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11/46 19 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 45 to 3/11/46 19 , and that I last saw h alive on 3/11 19 46

Immediate cause of death Carcinoma of both ovaries — Duration 7 mos

Due to

Due to

Other Conditions Abdominal ascites 3 mos
Cachexia 2 mos
(Include pregnancy within 3 months of death)

Date of operation Aug 1945

Major findings of operation: Same as above

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Nutter M.D.

Address 1 W. Chase St. Date signed 3/12/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

638306 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo 3da
(e) Length of stay in Baltimore (yrs., mos., or days) 5 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. UNIVERSITY PKY. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME RALPH ROBBINS SCHRENKEISEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: Marie Brady Schrenkeisen
6 (c) If alive, give age 7 years
7. Birth date of deceased (mo., day, yr.) Oct. 7, 1891
8. AGE: Years 54 | Months 5 | Days 5 | If less than one day hr. min.
9. Birthplace NEW YORK City (Town, county, and state)
10. Usual Occupation President
11. Industry or business Chesapeake Cadillac Co.
FATHER 12. Name MARTIN H. SCHRENKEISEN
13. Birthplace NEW YORK City
MOTHER 14. Maiden Name MARY [illegible] SLATER
15. Birthplace NEW YORK City
16 (a) Informant Mrs. Marie B. Schrenkeisen
(b) Address 104 W. University Parkway
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/12/46 (month) (day) (year)
(c) Cemetery or crematory Woodlwan Cem.
Location Bronx, N. Y.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (b) (Signature of registrar)

MAR 12 1946 Registrar for Williamsville, N.Y.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 4:07 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1946 to Mar. 12 1946 and that I last saw him alive on Mar. 11 1946.

Immediate cause of death: CARCINOMA OF BLADDER — Duration:
Due to:
Due to:
Other Conditions: Arter. CVD

(Include pregnancy within 3 months of death)
Date of operation Jan. 17, 1946
Major findings of operation: CARCINOMA of BLADDER
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gayle B. Arnold M. D.
Address U.M.H. Date signed 3-12-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638307 — BALTIMORE CITY HEALTH DEPARTMENT — 638307

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Mt. Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 6065 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** GEORGE J. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-9066

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 - 1886

8. AGE: Years 59 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name George J Smith
13. Birthplace Md

MOTHER — 14. Maiden Name Anne Hyland
15. Birthplace unknown

16 (a) Informant Mrs Annie Smith
(b) Address 6065 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md

18 (a) Funeral director Grant Th Selby
(b) Address 814 W 36 St

19 MAR 12 1946 (Date rec'd by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1946, at 1.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1946, to 3/11 1946, and that I last saw h.IM. alive on 3/11 1946.

	Duration
Immediate cause of death PULMONARY EDEMA + RESPIRATORY FAILURE	5 DAYS
Due to HEART FAILURE	
Due to HYPERTENSIVE HEART DISEASE	
Other Conditions POSSIBLE BEGINNING BRONCHOPNEUMONIA (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address 1738 E. 28th St. Date signed 3/11/46

Huntington Williams, M.D.

G38308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G38308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 523 Lyndhurst St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Lyndhurst St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Hennessy

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-0172

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 - 1885

8. AGE: Years 60 | Months 10 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Stock Clerk

FATHER
12. Name Thomas Hennessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Furlong
15. Birthplace Ireland

16 (a) Informant Agnes Hennessy
(b) Address 523 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) MAR 12 1946 (Date rec'd by registrar)

Huntingtor Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13-46 19 to 3-10-46 19 and that I last saw h.. alive on 3-9-46 19

Immediate cause of death: Heart failure — Duration:

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Lindel M. D.
Address 270 3 Chauncey Date signed 3-11-46

VS 150

X

Please write plainly in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 638309 8

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Edmonson ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Edmonson ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lee

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	widowed

6 (b) Name of husband or wife Mrs. Martha Lee
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-10-73

8. AGE: Years	Months	Days	If less than one day
72	5	1	hr. min.

9. Birthplace Lancaster Co. Va (Town, county, and state)
10. Usual Occupation General Jobber
11. Industry or business

FATHER
12. Name Richard Lee
13. Birthplace Lancaster Co. Va

MOTHER
14. Maiden Name Mildred ?
15. Birthplace Lancaster Co Va

16 (a) Informant Mrs Ena Smallwood
(b) Address 1411 Edmonson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Balto. Co. Md.

18 (a) Funeral director Saml. W. Chase & Son
(b) Address 630 N. Gilmor St

19 (a) MAR 12 1946 (Date received by registrar)

Hunting for Williamson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-1946, at 1030 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1941 to 3-11-1946, and that I last saw him alive on 3-10-1946.

Immediate cause of death: Sarcoma of Intestines — Duration over 6 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 Stricker St Date signed 3-11-46

X

G38310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8713

G38310 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Bentalou street
(c) Hospital or institution: N.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-5

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Bentalou street
N. (If rural give location)
(e) If foreign born, how long in U. S. A.? NO years

3 (a) FULL NAME LILLIAN M. TOOHEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife Thomas F. Toohey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1892

8. AGE: Years	Months	Days	If less than one day
53	7	18	..... hr. ..... min.

9. Birthplace Iowa (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name ------- Durbin
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Joseph P. Healy
(b) Address Drovers & Mechanics Bk. Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 N. Mt. Royal Ave.

MAR 12 1946 (Date received by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7- 1945, to 3-10- 1946, and that I last saw h.. alive on March 8 1946.

Immediate cause of death (a) Bronchial Neurtis — Duration [illegible]
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 3-11-46.

VS 3

X

638311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1612

638311

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 11/46

8. AGE: Years — Months — Days — If less than one day 9 hr. 26 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles A Little
13. Birthplace Md

MOTHER
14. Maiden Name Frances J Lovett
15. Birthplace North Carolina

16 (a) Informant Mrs Nancy McHugh
(b) Address 504 Allendale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1946 (month) (day) (year)
(c) Cemetery or crematory Mem Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Harry N Wright
(b) Address 4101 Edmondson ave
(c) MAR 13 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 11 1946, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11-46 19 to same 19, and that I last saw him alive on 3-11-46 19

Immediate cause of death	Duration
Pulmonary atelectasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Nogueira M. D.
Address Baltimore Gen Hospital Date signed 3-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38312 G38312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1725 E. Federal Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY ANDREW DODSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna Beitzel Dodson
6 (c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) Aug. 28, 1883

8. AGE: Years	Months	Days	If less than one day
62	6	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business 1712 E. Federal St.

FATHER
12. Name Andrew Dodson
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Reynolds
15. Birthplace ?

16 (a) Informant Mrs. Anna Dodson
(b) Address 1725 E. Federal Street

17 (a) Burial (b) Date thereof 3-13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore, Md.
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY
19 (a) (b) Huntington, Md.

MAR 13 1946

VS 150

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH Mar. 10 1946 at 12.01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1943 to Mar. 10 1946 and that I last saw h[illegible] alive on Mar. 9, 1946.

	Duration
Immediate cause of death Coronary Thrombosis	15 min.
Due to Arteriosclerosis and Chronic Myocarditis	5 yrs.
Due to	
Other Conditions Bilateral Pyramidal Tract Paralysis.	6 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Ernest Lev. M.D.
Address 1601 N Broadway Date signed 3/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38313 G38313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 Elliott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEDWITH Thomas M.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215 07 2224

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation BARTENDER

11. Industry or business

FATHER
12. Name THOMAS M.LEDWITH
13. Birthplace MD.

MOTHER
14. Maiden Name MARY T.ELLWOOD
15. Birthplace MD.

16 (a) Informant JOHN F.LEDWITH (BROTHER)
(b) Address 1707 E.33rd.ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR.13/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S.WOLFE ST.

19 (a) (b)

MAR 13 1946 Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1946, at 12:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerot.i C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3/14/46

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C Allen Thayer
G38514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1942 Registered No. G38514

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gorman Downing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife Blanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31, 1903

8. AGE: Years	Months	Days	If less than one day
42	6	12	hr. min.

9. Birthplace Bivalve Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Real estate

FATHER
12. Name Wm. Downing
13. Birthplace Bivalve Md.

MOTHER
14. Maiden Name Annetta Insley
15. Birthplace Bivalve, Md.

16 (a) Informant Ralph Insley
(b) Address Bivalve, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar. 14/46 (month) (day) (year)
(c) Cemetery or crematory Bivalve M.P. Cemetery
Location Bivalve Md

18 (a) Funeral director C Glen Messick
(b) Address Bivalve Md

19 (a) (Date received by registrar) (Huntington Nottingham Md)

MAR 13 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1946, at 12:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s. death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature L. J. Lalumiere M.D.
Medical Examiner.
Date signed 3/12/46

G38315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/30

G38315

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4101 Hayward Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Hayward Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE VIRGINIA STEELE

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert L. Steele, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 16, 1902

8. AGE: Years 43 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace: Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: U. S. Navy

FATHER
12. Name: Harvey W. Franklin
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden Name: Edna May Grossnickle
15. Birthplace: Carroll Co., Md.

16 (a) Informant: Mr. Robert L. Steele, Sr.
(b) Address: 4101 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 13 1946 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 10, 1946 at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1946 to March 10 1946 and that I last saw her alive on March 10 1946

Immediate cause of death	Duration
Acute Myocarditis	12 days
Due to Acute Nephritis	12 days
Due to	
Other Conditions Secondary Anemia	2

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Nichols M.D.
M. D.
Address Pikesville, Md. Date signed 3/13/46

PLEASE WRITE PLAINLY, WITH INK ALONG LINE. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38516 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John Street & Hoffgotte Ave.
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Annah Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Amelia Ida Schiminger

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1880

8. AGE: Years	Months	Days	If less than one day
66	—	14	hr. min.

9. Birthplace Baltimore Maryland.
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business home

FATHER
12. Name Rudolph Schiminger
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Amelia Hoffman
15. Birthplace Berlin Germany.

16 (a) Informant Miss Jennie Schiminger
(b) Address 2903 Annah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.

MAR 13 1946
VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12th 1946, at 8:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 11th 1946, to March 12th 1946, and that I last saw h[er] alive on March 12th 1946.

Immediate cause of death	Duration
Cerebral Vascular Hemorrhage	36 hrs.
Due to Hypertensive Cardio Vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature X H. A. Arias M. D.
Address Woman's Hospital Date signed 3/12/46

PLEASE WRITE PLAINLY, WITH ONLADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V43D

G38417
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital 76
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days)
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City or town~~ Church Home - Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Jane Mason

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife: William A. Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1862

8. AGE: Years	Months	Days	If less than one day
84	1	5	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John A. Ennis —
13. Birthplace Balto.

MOTHER
14. Maiden Name Sarah Henry
15. Birthplace Balto.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MAR 13

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1946, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1946 to 3-12 1946.
and that I last saw h~~e~~r alive on 3-11 1946.

Immediate cause of death	Duration
Congestive Heart Failure	Months
Due to Arteriosclerosis C.V.D.	Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home & Hosp. Date signed 3-12-46

X

G38518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G38518 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga & Dukeland
(c) Hospital or institution Hut Balt. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Gray

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Lorenzo E. Grey
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1867

8. AGE: Years 78 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace: Arundel Co., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry C. Linstid
13. Birthplace: Arundel Co., Md.

MOTHER
14. Maiden Name: -- Gordan
15. Birthplace: Boston, Mass.

16 (a) Informant: Miss Florence Linstid
(b) Address: 617 Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md. Huntingtn for Williams, Mgr

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 March 1946 at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 March 1946 to 12 Mar 1946 and that I last saw h alive on 12 Mar 1946

Immediate cause of death	Duration
Cer. Failure	
Due to Coronary Occlusion	
Due to Arteriosclerotic C.V. Renal Dis	
Other Conditions Pt. has pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leah Adreeff M.D.
Address Hut Balt Gen Hosp Date signed 3/14/46

VS 150

PRINT WITH PENCIL, WITH ONE LETTER IN A SPACE. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G38319 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balti
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4327 PK. Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Benjamin Rosen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Dena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

FATHER 12. Name Moses Rosen

13. Birthplace Russia

MOTHER 14. Maiden Name Rivka —

15. Birthplace Russia

16 (a) Informant Mrs. Rose Fagman

(b) Address 4327 PK. Heights Ave.

17 (a) Burial (b) Date thereof 3-13-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jos. Levine Inc

(b) Address 1439 E. Balto. St

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 15 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 March 1946, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 March 1946, to 13 March 1946 and that I last saw h[illegible] alive on 13 March 1946.

Immediate cause of death Coronary Failure — Duration

Due to Nephritis

Due to Carcinoma of the Stomach.

Other Conditions Benign Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Asher Hollander

Address Sinai Hospital Date signed 13 March 1946
M. D.

Asher Hollander

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139B

G38320 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Fenchurch Rd Guilford
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Julma Calloway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Walter B Calloway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1879

8. AGE: Years	Months	Days	If less than one day
66	11	10	min.

9. Birthplace Gossen Ind
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name	Orlando Kline
13. Birthplace	Gossen Ind
MOTHER 14. Maiden Name	Cora Montgomery
15. Birthplace	Pennsylvania

16 (a) Informant Walter B Calloway
(b) Address 3810 Fenchurch Rd Guilford

17 (a) Removal (b) Date thereof Mar 14 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Glen Haven
Location Harrison Ohio

18 (a) Funeral director Henry N Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd) MAR 13 1946 (b) Registrar Williamson Hospital

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1946, to 3/12 1946, and that I last saw her alive on 3/12 1946.

Immediate cause of death	resp failure	Duration
Due to	pulmonary embolism	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation 3/11/46
Major findings of operations nodules of ovaries
Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James R McIntosh Jr M.D.
M. D.
Date signed 3/14/46

G38561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83a (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev Timothy B Kenny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1870

8. AGE: Years	Months	Days	If less than one day
75	7	8	hr. min.

9. Birthplace Piedmont W. Va.
(Town, county, and state)
10. Usual Occupation Catholic Priest
11. Industry or business

FATHER
12. Name Timothy J Kenny
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Grayney
15. Birthplace Galway Ireland

16 (a) Informant Patrick Joseph O'Brien
(b) Address Luke Md

17 (a) Removal (b) Date thereof Mar 14 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Western Port Md

18 (a) Funeral director Henry W Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by Reg.) MAR 13 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6- 1946, to 3-11- 1946, and that I last saw him alive on 3/11 1946.

Immediate cause of death Resp Insufficiency

Due to Intramastoid hemorrhage

Due to possible thrombosis & phlebitis due to trauma

Other Conditions Lt facial - left.

(Include pregnancy within 3 months of death)

Date of operation 3/10/46

Major findings of operation: Intramastoid hemorrhage - left

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/2
(a) Accident, suicide, or homicide Accident on 3/9/46
(b) Date of occurrence 3/9/46 at M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Mt. Royal Ave While at work?
(Specify type of place)
(e) Means of injury Auto accident

23. Signature Hunterton Williams M. D.
M. D.
Address University Hosp Date signed 3/12/46

Hunterton Williams M.D. J. Meeder, M.D.

G38322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 838

Registered No. G38322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Mc Donough
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Mc Donough St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME John b. Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Deceased

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years: 70 - 7 Months: 4 Days: 9 If less than one day: hr. min.

9. Birthplace: Va (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Christopher Mills
13. Birthplace: Va

MOTHER
14. Maiden Name
15. Birthplace: Va

16 (a) Informant: Mary Carey
(b) Address: 904 Mc Donough

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3 (month) 46 (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem
Location: A. A. County

18 (a) Funeral director: Mrs. N. A. Elliott Daughter
(b) Address: 1129 N. Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1946, at 1 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1945 to March 9 1946, and that I last saw h[illegible] alive on 3-7 1946.

Immediate cause of death: apoplexy — Duration: Instant

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Edward Fisher M. D.
Address: 1642 Monument Date signed: 3-9-46

VS 150

PRINT OR TYPE ENTRIES WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1701

G38523 Registered No.

Type or print plainly in ink. Fill in all items. Report causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Seagull St (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Waters

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1905

8. AGE: Years 41 | Months 2 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaac Speller
13. Birthplace Va

MOTHER
14. Maiden Name Annie Evans
15. Birthplace Va

16 (a) Informant William Waters
(b) Address 517 Seagull Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo H. Kelson
(b) Address 1303 Pennsylvania Ave.

19 (a) ..... (b) .....
(Date received by registrar) Registrar

MAR 13 1946

Thurston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946 at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured neck
Transection of Cord (Spinal)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 17, 1946 25/2 M.
(b) Where did injury occur? Hanover Redbird
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by car - (auto)

23. Signature Benedict Petrulis M.D.
Medical Examiner.
Date signed 3-12-46

X

G38524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38524 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 N. Stricker St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Lilly Brooks Summerville

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 26, 1906

8. AGE: Years	Months	Days	If less than one day
39 40	8	15	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Brooks
13. Birthplace Md

MOTHER
14. Maiden Name Mary Beaney
15. Birthplace Md

16 (a) Informant Robert Eugene
(b) Address 2197 N. Stricker St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Interlude
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 303 Pulaski St

19 (a)..... (b)..... (Date rec'd by registrar) Registrar

MAR 13 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Fraser M.D.
Medical Examiner.
Date signed March 12 1946

Thurston Williams, M.D.

G38325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 64

G38325 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2873 Pelham ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Coulthard Jr. William Coulehart

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1945

8. AGE: Years: 1 | Months: 1 | Days: 22 | If less than one day: ######## hrs ######## min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William H. Coulthard
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Evelyn L. Coster
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Evelyn L. Coulthard
(b) Address 2873 Pelham Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 6 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymico-lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratz M.D. Medical Examiner.
Date signed March 12, 1946

G38326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G38326

HB # 97063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 9
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 643 Sterling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Hamlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1927

8. AGE: Years 18 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sam Hamlett
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Hamlett
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-46 (month) (day) (year)
(c) Cemetery or crematory Appamattox
Location Virginia

18 (a) Funeral director Adolphus Halstead
(b) Address 2 E Druid Hill Ave

MAR 13 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1946, at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2, 1945, to March 11, 1946, and that I last saw her alive on Mar. 11, 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.

Address Balt. City Hosp. Date signed 3/12/46

X

BALTIMORE CITY HEALTH DEPARTMENT

G38327 CERTIFICATE OF DEATH 1946 G38327

Registered No.

Please write the causes of death clearly and legibly. Physicians, please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or Institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Howard St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME John Kliszes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Clara F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3rd 1900.

8. AGE: Years	Months	Days	If less than one day
45	10	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Maintenance Dept.
11. Industry or business Esplanade.

FATHER
12. Name Matthew Kliszes
13. Birthplace Lithuania

MOTHER
14. Maiden Name Eva Gudiskis
15. Birthplace Lithuania

16 (a) Informant Mrs Clara F. Kliszes
(b) Address 819 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4420 Belair Road

18 (a) Funeral director John J. Cosgrove Son
(b) Address 901-903 Hollins St

MAR 13 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946, at 7 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Due to Atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarek M.D.
Medical Examiner.
Date signed 3-12-46

VS 151

G38528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38528 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1923 Frederick Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Leech Leach.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Hannah Leach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10-1861

8. AGE: Years	Months	Days	If less than one day
84	10.	1.	hr. min.

9. Birthplace London England
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace London. England

MOTHER
14. Maiden Name Unknown
15. Birthplace London. England

16 (a) Informant Francis H Leach
(b) Address 1732 Lakeland Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 14-46 (month) (day) (year)
(c) Cemetery or crematory Int. O Hill Mem
Location Baltimore Md

18 (a) Funeral director Maurice C. Suffel
(b) Address 1600 Mt. Royal Ave.

19 MAR 13 1946 (b) Huntington Williams M.D.
(Date rec'd by Local Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11/46 19.., at 9:57 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on a farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Dawson M.D.
Medical Examiner.
Date signed 3/17/46

VS 151

Fill in the causes of death clearly and legibly.

G38329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3/10

G38329
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 N. Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Sarah Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20 - 1874

8. AGE: Years	Months	Days	If less than one day
71	6	20	hr. min.

9. Birthplace St. Mary's Co., Md.
(Town, county and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Robert H. Carr
(b) Address 1620 Ashland ave

17 (a) Burial (b) Date thereof 3/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elgin O. Wilson
(b) Address 1000 Belair Ave

MAR 13 1946
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946 at 8:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to March 10 1946 and that I last saw h alive on March 10 1946

Immediate cause of death Bronchopneumonia — Duration 3 days
Due to Myocarditis
Due to Hypertension
Other Conditions Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
- Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elgin O. Wilson
Address 422 N. Bond St Date signed 3/12/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

638330 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1532 COVINGTON ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 COVINGTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE. E. ELLIOTT.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: FEM
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 27-1886

8. AGE: Years 60 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation MOTION PICTURE BOARD
11. Industry or business

FATHER
12. Name CHARLES. W. ELLIOTT
13. Birthplace MARYLAND

MOTHER
14. Maiden Name CAROLINE VOGELMAN
15. Birthplace GERMANY

16 (a) Informant MISS RACHEL S. ELLIOTT
(b) Address 1532 COVINGTON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-15-46 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEM
Location BALTO MD

18 (a) Funeral director Bernard E. Hartig
(b) Address 121 E WEST ST

19 (a) — (b)
(Date received by Local Registrar) Registrar

MAR 13 1946 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 12 1946 at 345 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Mar 12 1946, and that I last saw h[illegible] alive on Mar 12 1946

Immediate cause of death	Duration
Cerebral hemorrhage	May 1946
from Knowledge	
Due to Malignancy	
Due to	
Other Conditions Hypertension Cystitis	2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Daily
Address [illegible] Medical Arts Date signed Mar 13/46

G38531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G38531 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Prince Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Stinnett

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1884

8. AGE: Years	Months	Days	If less than one day
61	11	29	hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name Thomas Stinnett
13. Birthplace Md

MOTHER 14. Maiden Name Mary Cochrane
15. Birthplace Md

16 (a) Informant Elmer F. Stinnett
(b) Address 2926 Linwood Place

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Prince Frederick, Md

18 (a) Funeral director A. A. Harkum & Son
(b) Address Mutual, Md.

19 (a) MAR 13 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946 at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/1946 to 3/12/1946, and that I last saw him alive on 3/12 19

Immediate cause of death	Duration
(a) Coronary Thrombosis	
Due to (b) Generalized Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Hirschmann M.D.
Address Sinai Hospital Date signed 3/13/46 M. D.

VS 150

J. H. Hirschmann

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38332 ✓ G38332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Woodridge road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Woodridge road
(If rural give location)
(e) If foreign born, how long in U. S. A.? NO years

3 (a) FULL NAME MARGARET VIRGINIA KELLY

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Edmund B. Kelly
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1910

8. AGE: Years	Months	Days	If less than one day
35	6	7	____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name George G. O'Brien
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Bessie Gross
15. Birthplace Carroll Co. Md.

16 (a) Informant Mr. Edmund B. Kelly
(b) Address 4010 Woodridge road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son Inc.
(b) Address 118 W. 28th Royal Ave

19 (a) MAR 13 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946 at 8-10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6- 1946 to Mch 11 1946 and that I last saw her alive on Mch 10- 1946

Immediate cause of death	Duration
Carcinoma of Breast	2 yrs
Due to	
Due to	
Other Conditions Metastases in Lungs.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 3/12/46

VS 3

X

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

BALTIMORE CITY HEALTH DEPARTMENT ✓ 638333

CERTIFICATE OF DEATH 937

Registered No. 638333

638333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Wilhelm St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HENRY MILLER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife: Barbara Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR 30 1879

8. AGE: Years	Months	Days	If less than one day
66	10	12	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business Self

FATHER
12. Name GEORGE MILLER
13. Birthplace BALTO. Md.

MOTHER
14. Maiden Name LOUISE Kornman
15. Birthplace BALTO. Md.

16 (a) Informant WM. I. MILLER
(b) Address 4407 TOWANDO AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick Avenue

19 (a) [illegible] (b) [illegible] Huntington Williams, Mgr

MAR 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1946, at 4:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 11 1946, to MAR 12 1946, and that I last saw h[illegible] alive on Mar 12 1946.

Immediate cause of death	Duration
CARDIO-RESP. FAILURE	
Due to Arteriosclerotic CVD?	
Due to	
Other Conditions CARBUNCLE & SEPTICEMIA? (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Doyle J. Straub M. D.
Address U. M. H. Date signed 3-12-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G38334 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Lanvale
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Lauretta Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Z. LaPlanche

3 (b) If veteran, name war None

3 (c) Social Security Account No. 216-12-0044

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ernest R. LaPlanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1894

8. AGE: Years 51 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace La Plata, Charles County, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name ?
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Margaret Ann LaPlanche
(b) Address 2536 Lauretta Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-46 (month) (day) (year)
(c) Cemetery or crematory Balto. Memorial
Location Baltimore, Md.

18 (a) Funeral director George L. Schwartz
(b) Address 2101 Frederick Avenue

19 3-13-1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 3 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1946, to 3/12 1946, and that I last saw h-er alive on 3/12 1946

Immediate cause of death Lobar Pneumonia

Due to Chronic Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Baldwin M.D.
Address West Baltimore General Hospital Date signed 3/13/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38535 ✓ G38535

G38535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Deitchman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-1228

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Late Isadore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov, 11, 1887

8. AGE: Years	Months	Days	If less than one day
58	4	2	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Hyman Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Leah Snyder
15. Birthplace Russia

16 (a) Informant Morton J. Deitchman
(b) Address 1701 N. Pulaski St.

17 (a) Burial (b) Date thereof 3/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 N. Forest Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946 at 4:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 13 1946 and that I last saw her alive on March 13 1946

Immediate cause of death: Cardiac failure and Uremia — Duration
Due to: Myocarditis
Due to: Chronic Nephritis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W Reedale
Address 2314 - 22. Nor 92 Date signed 3/14/46
M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G38336 BALTIMORE CITY HEALTH DEPARTMENT G38546 No.

CERTIFICATE OF DEATH 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1640 N. Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1640 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Mazaroff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Posvohler (Town, county, and state)

10. Usual Occupation

11. Industry or business Poultry Business

FATHER
12. Name Joseph Mazaroff
13. Birthplace Russia

MOTHER
14. Maiden Name Rosa Israelson
15. Birthplace Russia

16 (a) Informant Mrs. Lena Mazaroff
(b) Address 1640 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mount Carmel Cem.
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) 1126 W. North Ave.

19 (a) MAR 14 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 7:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 , to 3/12/46 19 , and that I last saw h[illegible] alive on 3/12/46 19 .

Immediate cause of death: Acute coronary thrombosis — Duration: 1/2 hr

Due to: Coronary arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2904 Reist Rd Date signed 3/13/46 M. D.

G38337 BALTIMORE CITY HEALTH DEPARTMENT G38337
CERTIFICATE OF DEATH 1637 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Liberty Hgts (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah L. Diener

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Israel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1891

8. AGE: Years 55 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Morris Samuels
13. Birthplace Poland

MOTHER 14. Maiden Name Baila Diener
15. Birthplace Poland

16 (a) Informant Israel Diener
(b) Address 3909 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar/14/46 (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim Cem.
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 West North Ave

19 (a) MAR 17 1946 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946 at 5 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia due to bichloride of mercury poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/12/46 at : M.
(b) Where did injury occur? 3909 Liberty Hghts Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Ingestion of Bichloride of mercury

23. Signature Benedict Skitarelic M.D. Medical Examiner
Date signed 3-13-46

VS 151

Complete age is especially important. Physicians: please write the causes of death clearly and legibly.

38538 ✓ G38538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 S. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Trivisonis or Trevisonno

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 217-05-4676

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Angela Maria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-30-1880

8. AGE: Years 65 | Months 3 | Days 11 | If less than one day: hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Daniel Trivisonis
13. Birthplace Italy

MOTHER 14. Maiden Name Theresa Micozzi
15. Birthplace Italy

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Arnold Wells Noel
(b) Address 52 N. Morley St.

19 MAR 14 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946 at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1946, to Mar 11 1946, and that I last saw h alive on Mar 11 1946.

Immediate cause of death: Carcinoma of Tongue — Duration
Due to
Due to
Other Conditions: Metastases to regional nodes (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Cannon Jr. M. D.
Address Johns Hopkins Hosp. Date signed 3/11 46

VS 150

X

...ete the causes of death clearly and legibly. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the...

G38539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G38539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pealesut & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Riseckent Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Tony Sapresti — Lo Presti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Grace Sapresti

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 25, 1888

8. AGE: Years	Months	Days	If less than one day
57	11	18	..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business 919 Stiles St.

FATHER
12. Name Anthony Sapresti
13. Birthplace Italy

MOTHER
14. Maiden Name Anne ?
15. Birthplace Italy

16 (a) Informant Mrs. Grace Sapresti
(b) Address 3001 Roosevelt Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Monroe St

MAR 14 1946 (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1946 to 3/13 1946 and that I last saw him alive on 3/13 1946.

Immediate cause of death: Generalized Purulent Peritonitis and Sepsis
Due to: Perforated Appendix
Due to:
Other Conditions: Chronic Cholecystitis, Gallstones, Thyroid C.V. Disease
Date of operation March 11 1946 (Include procedure within 3 months of death)
Major findings of operation: Perforated appendix with diffused gall bladder. Subdiaphragmatic abscess
of autopsy:

Duration
3 days

PHYSICIAN
Underline the cause to which certificate should be classified statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Larry Sanchez M.D.
Address Mercy Hospital Date signed March 13 1946

J. LARRY SANCHEZ, M.D.

G38340 JL - 93326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38340 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry P. Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Tillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1897

8. AGE: Years 48 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Cornish
13. Birthplace Md.

MOTHER
14. Maiden Name Lula Clark
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Baltimore

18 (a) Funeral director Chas. H. Alexander
(b) Address 1200 McCulloh St

19 MAR 14 1946 (b) Huntington Williams, M.D.
(Date received by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 13 1946; at 3:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945 to Mar. 13 1946 and that I last saw h im alive on Mar. 13 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Hypertensive Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Gerygor M. D.
Address Baltimore City Hall. Date signed 3-13-46

VS 150

Orie C. Falls ✓

G38341 BALTIMORE CITY HEALTH DEPARTMENT G38341

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Guilford (Rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orie C. Falls

3 (b) If veteran, name war W.
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband Albert T. Falls

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10th 1860

8. AGE: Years 85 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Bedford Co. Va.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Isaac Rusher
13. Birthplace Va.

MOTHER 14. Maiden Name Judith A. Owen
15. Birthplace Va.

16 (a) Informant Mrs. Sallie Thompson
(b) Address 2007 Guilford Ave

17 (a) Burial (b) Date thereof 3/15/46
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 14 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946 9 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gastric ulcer
Cardio vascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed 3-13-46

X

The cause of death clearly and legibly. Physicians: please write

G38542 G38342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1780

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Wilhelm St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James P Morrissey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Marguerite C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1870

8. AGE: Years 75 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Sumpter S.C. (Town, county, and state)

10. Usual Occupation Retired Painter

11. Industry or business Balto. Transit Co.

FATHER
12. Name (Unknown) Morrissey
13. Birthplace Ireland

MOTHER
14. Maiden Name "
15. Birthplace England

16 (a) Informant Marguerite C. Morrissey
(b) Address 1833 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

MAR 14 1946 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1946, at 4:50 P M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions Carbon Monoxide Asphyxia — Partial (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 3/12/46 at about 7 P M. 1946
(b) Where did injury occur? 1833 Wilhelm St.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Partially asphyxiated by smoke & fire

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3/13/46

VS 151

638343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

638343 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4400 Marble Hall Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Marble Hall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles B Hearn

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Hearn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6th 1906

8. AGE: Years 40 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name James J Hearn
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Catherine Leonard
15. Birthplace London N J

16 (a) Informant Elinor Levell
(b) Address 1923 "G" St Washington D C

17 (a) Removal (b) Date thereof 3/14/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Holy Sepulchre Location Philadelphia Pa.

18 (a) Funeral director William Cook Jose
(b) Address 1217 St. Paul St

19 (a) MAR 14 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946; at 12 N M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945, to March 13 1946, and that I last saw him alive on March 13 1946.

Immediate cause of death: Carcinoma metastasis — Duration 2 months

Due to: Carcinoma of the right lung — ? ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 1/2/46

Major findings of operation: Carcinoma of the lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 20 E. Preston Street Date signed 3/17/46

G38344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

G38344 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Kennedy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd V. Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Verbena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/3/1904

8. AGE: Years	Months	Days	If less than one day
41	4	10	hr. min.

9. Birthplace Shenandoah Va.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Western Electric Co.

FATHER
12. Name Arthur Davis
13. Birthplace Va

MOTHER
14. Maiden Name Hetty Mae Stanley
15. Birthplace Va

16 (a) Informant Mrs Verbena Davis
(b) Address 2037 Kennedy Ave

17 (a) Removal (b) Date thereof 3/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Shenandoah
Location Va.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 MAR 14 1946 (b) Huntington Williamson, M.D.
(Month, day, year)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 19 46, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 19 46 to 3/13 19 46
and that I last saw him alive on 3/13 19 46

Immediate cause of death Cardiac Failure	Duration
Due to Generalized Abdominal Adenocarcinomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Elwood
Address St Agnes Hosp Date signed 3/13/46 M. D.

VS 150

G38345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G38345
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 N. Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boy Diggins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			3 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilmer A Diggins
13. Birthplace Va

MOTHER
14. Maiden Name Ellen Beatrice Sutch
15. Birthplace Balto, Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5, 1946 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1946 to Mar 5 1946, and that I last saw him alive on Mar 5 1946

Immediate cause of death	Duration
Prematurity	
Due to Unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Goldmann
Address 2316 Eutaw Pl Date signed 3/13/46

VS 8

3364

638346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. 638346

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 King Avenue Box 395 + 6
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Howard Krenek

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 hrs

8. AGE: Years	Months	Days	If less than one day
			2 hrs hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Gilbert Krenek
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Marie Louise Hankins
15. Birthplace Baltimore, County

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 14 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1946, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death — Duration

ery throblastosis fetalis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy enlarged liver & spleen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irwin Krieger, M.D.
M. D.
Address Sinai Hospital Date signed

VS 3

3363

G38347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G38347

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5067 N. Fulton Ave #23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boy Kaminkow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-46

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Kaminkow
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Frances Marie Smith
15. Birthplace Balto, Md

16 (a) Informant Mother Frances Kaminkow
(b) Address 5067 Fulton Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 13 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946, at 8:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death

Duration

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Seaman, M.D.
M. D.

Address Sinai Hospital Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3382

G38348 ✓ G38348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Normandy Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mina A. Sheppard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James E. Sheppard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 1, 1905.

8. AGE: Years: 41 | Months: 1 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Canada (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George L. Simpson
13. Birthplace: Canada

MOTHER
14. Maiden Name: Jennie Sidal
15. Birthplace: Canada

16 (a) Informant: James E. Sheppard
(b) Address: 420 Normandy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/15/46 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: 3801 Frederick Rd.

18 (a) Funeral director: Harry H. Kuhtze
(b) Address: 4101 Edmondson Ave.

19 (a) MAR 14 1946 (b) Huntingtn Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1946, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 1945 to Feb 27 1946. and that I last saw her alive on Feb 27 1946

	Duration
Immediate cause of death: Coronary occlusion	6 years
Coronary artery disease	
Due to: Hypertension	21 years
Due to: Toxemia of pregnancy	21yrs ago
Other Conditions: Angina pectoris	
Paroxysmal nocturnal dyspnea	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature: Caroline Bedell Thomas M. D.
Address: Johns Hopkins Hospital Date signed: 3/13/46

VS 150

638349 JL - 99764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 638349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. City Hospts.
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 309 N. Gilmor St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Green

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Married

6 (b) Name of husband or wife Curtis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1908

8. AGE: Years	Months	Days	If less than one day
38	2	9	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David L. Bell
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Roman
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof March 14, 1946 (month) (day) (year)
(c) Cemetery or crematory Martinsburg W. Va.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

MAR 14 1946 (Date rec'd by registrar) Katie R. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 7, 1946 to Mar. 12 1946 and that I last saw h er alive on Mar. 12 1946.

Immediate cause of death Embolism Pulmonary embolism

Due to Streptococcus Viridans

Due to Cyanosis, Dyspnea due to Rheumatic heart disease

Other Conditions Pulmonary congestion.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

Duration: P

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Gilfoyle M. D.
Address Balt. City Hosp. Date signed 3-13-46

VS 150

G38350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No. G38350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214½ Pennsylvania Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dempsey Tinsley Mason

3 (b) If veteran, name war

3 (c) Social Security Account No. 223-20-2008

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1923

8. AGE: Years	Months	Days	If less than one day
22	4	17	hr. min.

9. Birthplace Halifax County, Virginia (Town, county and state)

10. Usual Occupation Hospital Orderly

11. Industry or business

FATHER
12. Name Thomas Mason
13. Birthplace Halifax Co., Va.

MOTHER
14. Maiden Name Annie Buxley
15. Birthplace Halifax Co., Va.

16 (a) Informant Sister - Mildred Mason
(b) Address 1802 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Presstman St

MAR 14 1946 (Date received by Registrar) (b) [illegible] Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9 1946, at 2 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1946, to 3-9 1946, and that I last saw h. alive on 3-9 1946.

Immediate cause of death: Tuberculous Meningitis

Due to: Miliary Tuberculosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: ✓

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Methejah Spragins
Address Sydenham Hosp. Date signed 3-11-46 M. D.

VS 150

X

G38351 JL - 96436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G38351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 10
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Cumberland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Arthur Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1911

8. AGE: Years	Months	Days	If less than one day
34	7	19 20	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Jackson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Pryor
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressstman St

MAR 14 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 6:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1946, to Mar. 12 1946, and that I last saw h. im alive on Mar. 12 1946.

Immediate cause of death: Tuberculous Meningitis — Duration: 2

Due to:

Due to:

Other Conditions: Pulmonary Tuberculosis Tuberculous [redacted] Laryngitis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B Copeland Jr M.D.

Address Balt City Hosp. Date signed 3/13/46

VS 150

X

638352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

638352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 Woodbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Woodbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Wilkerson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26 1903

8. AGE: Years	Months	Days	If less than one day
43	1	15	hr. min.

9. Birthplace Salt. Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Adam Wilkerson
13. Birthplace Va.

MOTHER 14. Maiden Name Annie Thomas
15. Birthplace Va.

16 (a) Informant Daisy Saunders
(b) Address 2518 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 MAR 14 1946 (Date rec'd by registrar) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946 at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to March 10 1946 and that I last saw h[illegible] alive on March 9 1946.

Immediate cause of death Chronic Nephritis. (Uremia) — Duration Complete yrs.
Due to — Duration
Due to — Duration
Other Conditions Rheumatic Heart disease — Duration Complete yrs.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph L Young M.D.
Address 1424 Mt Vernon Pl Date signed 3/12/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as to information made on certificate. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38353 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W Caroline
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Rockville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Hogans

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1898

8. AGE: Years	Months	Days	If less than one day
47 48	9	8	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Farm hand
11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Francis Neal (nurse)
(b) Address Rockville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4, 17, 46 (month) (day) (year)
(c) Cemetery or crematory Rockville, Md.
Location

18 (a) Funeral director B. L. Snowden
(b) Address Rockville, Md.

19 (a) (Date rec'd by registrar) (b) Williamsville

MAR 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/46 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1946, to 3/13 1946, and that I last saw him alive on 3/13 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Hypertensive Vascular disease	
Due to	
Other Conditions Tuberculosis Lung Abscess	

(Include pregnancy within 3 months of death)
Date of operation 3/13/46
Major findings of operation Lung Abscess
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Janovski
Address St Joseph's Hospital Date signed 3/14/46

G38354 ✓ G38354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. L4747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 E. Eager St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen Foster

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Married

6 (b) Name of husband or wife Willie Foster
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 9 1903

8. AGE: Years	Months	Days	If less than one day
42	10	15	hr. min.

9. Birthplace Farmville Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Radford Davis
13. Birthplace Va

MOTHER
14. Maiden Name Anna —
15. Birthplace Va.

16 (a) Informant Ada Foster
(b) Address 1918 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. G. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 15 15 N. Mt Elderry St

19 (a) Filed by clerk MAR 14 1946 Wilkinson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 2:05 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 7 1946, to Mar. 12 1946, and that I last saw her alive on Mar. 12 1946.

Immediate cause of death Lobar Pneumonia. — Duration 7 days.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Leighton Jr M. D.
Address 2129 Druid Hill Ave Date signed 3/13/46

638.55 BALTIMORE CITY HEALTH DEPARTMENT 638.55

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3w/k
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Hampton, Va (If outside city or town limits, write RURAL and give town)
(d) Street No. P.O. Box 87 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-17-1889

8. AGE: Years 57 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace W Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward J. Savage
13. Birthplace Va

MOTHER 14. Maiden Name Hannah Ashburn
15. Birthplace Pa

16 (a) Informant Lucinda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory
Location Hampton Va

18 (a) Funeral director Wm J Shaffer Sons
(b) Address Norfolk Va

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946 at 1 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1946 to Mar 13 1946, and that I last saw h.e.r. alive on Mar 13 1946

	Duration
Immediate cause of death Coronary occlusion with myocardial infarction	< 1 hr
Due to Arteriosclerotic heart disease	3 yrs.
Due to	
Other Conditions early uremia	

(Include pregnancy within 3 months of death).
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address John Hopkins Hosp. Date signed 3-19-46

MAR 20 1946 Hunter Williams M.D.

G38556 BALTIMORE CITY HEALTH DEPARTMENT G38556
CERTIFICATE OF DEATH *1312 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 James St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 James St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth E Zaun

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1868?

8. AGE: Years	Months	Days	If less than one day
77	8	20	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Eberhart Bergen
13. Birthplace Germany

MOTHER
14. Maiden Name Mary [illegible] Bergen
15. Birthplace Balto Md

16 (a) Informant William Zaun
(b) Address 2507 James St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Edward Faulstich
(b) Address 2119 Walbrook Blvd

19 (a) (b) Registrar
(Signature of registrar)

MAR 14 1946 Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1946 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1946 to March 13 1946 and that I last saw h[illegible] alive on March 1946.

Immediate cause of death	Duration
Anemia	5 days
Due to Cardio vascular disease	5 ?
Due to renal	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo McKieffer M. D.
Address 2470 Wash Blvd Date signed 3-14-46

G38357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G38357 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 South Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CARMELLA MARCELLINO

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Salvadore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 185[illegible]

8. AGE: Years 93 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Norman Russo
13. Birthplace: Italy

MOTHER
14. Maiden Name: Josephine ?
15. Birthplace: Italy

16 (a) Informant: Family
(b) Address: 1806 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road

18 (a) Funeral director: James L. McCauley
(b) Address: 130 E. Fort Ave.

19 (a) (Date received by registrar) (b) Huntington Williamson, M.D.

MAR 14 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4 1946, to 3/12 1946, and that I last saw h[illegible] alive on 3/11 1946.

Immediate cause of death	Duration
Broncho-Pneumonia	7 days
Due to	
Cardiac Dilatation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M. Messina
Address 1703 S. Charles St Date signed 3/13/46 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38358

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38358

CERTIFICATE OF DEATH 1946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Jas. Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Many years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Stalkhausen (Mary Louise Stockhausen)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Henry, Sr.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 29, 1864

8. AGE: Years: 81 | Months: 3 | Days: 12 | If less than one day: 13 hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Housewife.

11. Industry or business:

FATHER
12. Name: Frederick Haberkorn
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Miss Mary C. Roeper
(b) Address: 1803 E. 29th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3- -46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

MAR 14 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1946 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1946 to 3-12 1946 and that I last saw h[illegible] alive on 3-12 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Pulmonary Embolism	
Due to Bedridden	
Due to Fractured hip	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-5-46
Major findings of operation: Acute Gallbladder.
of autopsy: None done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/6
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence 1-19-46 at M
(c) Where did injury occur? 1406 E. 29th St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? NO
(e) Means of injury: Slipped and fell down stairs

23. Signature: Wm H. Frank M. D.
Address St. Jos. Hosp. Date signed 3-14-46

Approved by Benedict Skolaut, M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G38359 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 N. Vincent
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 N. Vincent (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Arrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Widowed

6 (b) Name of husband or wife Elsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
63 62			hr. min.

9. Birthplace Rocky Mount N.C. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name JONAS James Arrington
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Powell
15. Birthplace N.C.

16 (a) Informant Mary Jones
(b) Address 1613 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Saml. W. Chase & Son
(b) Address 638 N. Gilmor St

(c) (Date received) (b) Registrar's signature Huntington Williams M.D.

MAR 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 13 1946, at 3.15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Mch 1 1946 to Mch 13 1946, and that I last saw him alive on Mch 12, 1946

Immediate cause of death	Duration
Lobar Pneumonia	1 wk
Due to	
Due to	
Other Conditions Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dallez D. Taylor

Address 1522 Harlem Ave Date signed 3/13/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638:60 — BALTIMORE CITY HEALTH DEPARTMENT — 638:60

CERTIFICATE OF DEATH

94a — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Fleetwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. T. Wisebaugh
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Laverne Wisebaugh
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 29 1882

8. AGE: Years	Months	Days	If less than one day
63	3	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Chicken
11. Industry or business Transfer Co.

FATHER
12. Name John Wisebaugh
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Horseman
15. Birthplace Md.

16 (a) Informant Mrs. Laurine Wisebaugh
(b) Address 3024 Fleetwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) (b) (Date rec'd by registrar)

MAR 14 1946 — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1946, at 1:34 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1946 to 3/14 1946, and that I last saw him alive on 3/14 1946

Immediate cause of death Pulmonary Edema — Duration 6 hrs.

Due to Coronary Infarction — 17d

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. O'Kelly Jr. M. D.
Address Mercy Date signed 3/14

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G38361 — BALTIMORE CITY HEALTH DEPARTMENT — G38361 Registered No.

CERTIFICATE OF DEATH 124B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Ashton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ///
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Ashton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH M. NITSCH

3 (b) If veteran, name war ////// | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cletus J. Nitsch
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 22, 1885

8. AGE: Years 60 | Months 7 | Days 18 | If less than one day ******** hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William G. Schaeffer
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary McDonald
15. Birthplace Ireland

16 (a) Informant Mr. Cletus J. Nitsch
(b) Address 2500 Ashton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15/46 (month) (day) (year)
(c) Cemetery or crematory New Cathederal Cem.
Location Baltimore, Maryland

18 (a) Funeral director A. R. Pilpert & Son
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 14 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946 at 1: A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1946, to March 12 1946 and that I last saw her alive on March 12 1946.

Immediate cause of death Pulmonary Oedema — Duration

Due to Mitral Insufficiency

Due to Hypertension Arteriosclerosis

Other Conditions Cancer of Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Peters M. D.
Address 2151 Wilkens Ave Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638362 ✓ 638362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 S. Eulaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel D. Walter Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-7628

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Emma E.

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 7-20-93

8. AGE: Years	Months	Days	If less than one day
52	7	19	/ hr. / min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Machine Repair

11. Industry or business

FATHER 12. Name John Walter

13. Birthplace Md

MOTHER 14. Maiden Name Cecelia Franklin

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director F. B. Wippert & Son

(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by Registrar) (b) Registered No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946, at 8:34 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1946, to Mar 11 1946, and that I last saw him alive on Mar 11 1946.

Immediate cause of death Post-operative — Sub-total gastrectomy — Duration

Due to Carcinoma stomach

Due to

Other Conditions Fecal fistula post op

(Include pregnancy within 3 months of death)

Date of operation Feb 26, 1946

Major findings of operation: Carcinoma stomach

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address The Johns Hopkins Hosp. Signed 3-14-46

G38363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38363 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Parrish Pl
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Parrish Pl (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Seymour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 12, 1883

8. AGE: Years 52 | Months 10 11 | Days 29 | If less than one day hr. min.

9. Birthplace Northumberland Co Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Taylor Ball
13. Birthplace Va.

MOTHER
14. Maiden Name Julia [redacted]
15. Birthplace V.

16 (a) Informant Eleanor Walker
(b) Address 209 N Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Wm Katz R. Williams
(b) Address 922 W. Lexington St.

19 (a) 1946 (Date rec'd by reg.) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946; at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1946, to March 11 1946 and that I last saw h[illegible] alive on March 10 1946.

Immediate cause of death	Duration
Cardiac Vascular Disease	6 mos
Due to Decubitus (Bed Sore)	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the causes to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1928 Pa Ave Date signed 3/17/46

VS 150

G38364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Balto Eye, Ear & Throat Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Glenwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** HARRY (Henry) T. MUSGROVE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife MAUDE R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7-1876.

8. AGE: Years	Months	Days	If less than one day
69	5	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Wm Musgrove
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Crook
15. Birthplace Maryland

16 (a) Informant Albert M. Musgrave
(b) Address 3604 Yolanda Road Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt View Cem
Location Howard Co., Md.

18 (a) Funeral director C. Harry Wenz
(b) Address Ilchesville, Md.

MAR 14 1946 (Date rec'd by registrar)

(a) (b) Huntington Williamsport Md

VS 8

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 3/13 1946, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4 1946, to 3/13 1946, and that I last saw him alive on 3/13 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic CVD	
Due to Peripheral Vascular Occlusion	
Other Conditions Mesenteric Thrombosis	

(Include pregnancy within 3 months of death)
Date of operation Glaucoma Operation 3/5/46
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul M. Friedman
Address 1214 Eutaw Place Date signed M 3 D. 13 46

G38365 G38365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

489253 Registered No. 477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 248 S. Durham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (BOLESLAW) Benjamin Krawczykowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-3170

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife Josephine
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-87.

8. AGE: Years	Months	Days	If less than one day
58.	2	18	hr. min.

9. Birthplace Poland.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Krawczykowski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location Germantown Hill Rd.
18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 MAR 14 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 12 1946 and that I last saw he alive on March 12 1946.

Immediate cause of death Carcinoma of the Lung — Duration Years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy Carcinoma of Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Pedon
Address Johns Hopkins Hosp. Date signed 3/13/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38366 | BALTIMORE CITY HEALTH DEPARTMENT | G38366 Registered No.

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Elsinore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Elsinore Ave
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Leo Maguire

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Rosa M. Emory
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 2, 1?

8. AGE: Years	Months	Days	If less than one day
About 64	10	10	-- hr. --- min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Electric Supplies

FATHER
12. Name Joseph H. Maguire
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret McGuirk
15. Birthplace Maryland

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St.

17 (a) Burial (b) Date thereof 3/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address 805 N. Calvert Street

19 (a) 1946 Huntington Williams, M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Mar. 12 1946 and that I last saw h~~im~~ alive on March 11 1946.

Immediate cause of death	Duration
Myocarditis	2 mos.
Due to Hypertension	2 years
Due to —	
Other Conditions Pulmonary oedema	3 days.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bartus Baggott M. D.
Address 3812 Greenmount Ave Date signed 3/12/46

Bartus Baggott

V8 3

...correct as far as age is especially important. Physicians: please write the causes of death clearly and legibly.

938367 Harding
4810 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 938367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Northern Pkwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Northern Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Yarnall

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Griffith H. Yarnall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1876

8. AGE: Years	Months	Days	If less than one day
69	10	17	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name J. T. Taylor
13. Birthplace Penna.

MOTHER
14. Maiden Name Aelade Kaywood
15. Birthplace Penna.

16 (a) Informant Mr. Griffith Yarnall
(b) Address 3008 Northern Pkwy.

17 (a) Burial (b) Date thereof 3/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fernwood Cemetery
Location Del. Co. Penna

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

MAR 14 1946 (b) Huntington Williams M.D.
(Date received by Local Registrar) (Signature of Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1945 to 3/14 1946, and that I last saw her alive on 3/13 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 week
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Harding
Address 4810 Belair Rd Date signed 3/14/46 M. D.

VS 150

X

G38368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38368 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3135 Baker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3135 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Caroline Simonaire

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex W | 5. Color or race F | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Julius C. Simonaire

6 (c) If alive, give age 1878 years

7. Birth date of deceased (mo., day, yr.) May 25, ~~1867~~

8. AGE: Years	Months	Days	If less than one day
67	9	18	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frederick Ruhe
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Edna Smith
(b) Address 819 N. Augusta Ave.

17 (a) Burial (b) Date thereof 3/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) MAR 14 1946 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1946 at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gubitosa M.D.
Medical Examiner.
Date signed 3/13/46

VS 151

(over)

Complete the causes of death clearly and legibly. Physicians: please write the cause in space is specially important.

G38369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38369

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 431 Kenneth Square
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 Kenneth Square
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN F. BLEDSOE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Harriet Edna Bledsoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	17	hr. min.

9. Birthplace Ala.
(Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business Md. School for Blind

FATHER
12. Name John F. Bledsoe
13. Birthplace

MOTHER
14. Maiden Name Mary Birdsong
15. Birthplace

16 (a) Informant Mrs. Harriet E. Bledsoe
(b) Address 431 Kenneth Square

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 14 1946
(a) (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12, 1946 at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to March 12 1946 and that I last saw him alive on March 7 1946

Immediate cause of death: Acute Cardiac Dilatation — Duration: March 12 1946

Due to:

Due to: Chronic Myocarditis — Duration: a Months 7 Years.

Other Conditions: Cardiac Sclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Green
Address 3009 Evergreen Ave Date signed 3/14/46
Baltimore 14, Maryland

Huntington Williams, M.D.

Dr. Harbold
G33570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 51c

G33570
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5100 Arabia Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Arabia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wilbert Stanbaugh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Betsy Jane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1916

8. AGE: Years	Months	Days	If less than one day
29	10	21	hr. min.

9. Birthplace Altonna, Penna
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John N. Stanbaugh
13. Birthplace Pa.

MOTHER
14. Maiden Name Frances I. Reese
15. Birthplace Pa.

16 (a) Informant Mrs. Betsy Jane Stanbaugh
(b) Address 5100 Arabia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/46 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cem.
Location Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) (Date rec'd by registrar) (b) Registrar

APR 16 1946 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th, 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1944 to April 15 1946, and that I last saw him alive on April 15 1946.

Immediate cause of death	Duration
Carcinoma testicle (Teratoma)	1½ years
Due to	
Due to	
Other Conditions Metastasis to pelvic organs & liver	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold
Address 4706 Harford Road Date signed 4/16/46 M. D.

X

G38371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G38371 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4016 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel T. Tillinghast

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1878.

8. AGE: Years	Months	Days	If less than one day
67	9	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business George P. Thomas Co.

FATHER
12. Name Tillinghast
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Elizabeth H. Tillinghast
(b) Address 4016 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16/46. (month) (day) (year)
(c) Cemetery or crematory Church of God Cemetery
Location Uniontown, Md.

18 (a) Funeral director Harry H. Pilfyte
(b) Address 4101 Edmondson Ave.

19 (a) MAR 14 1946 (Date received by registrar) (b) Harry H. Pilfyte M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1946 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1946 to 3-14 1946 and that I last saw h alive on 3-14 1946

Immediate cause of death	Duration
Cerebral hemorrhage	one hour
Due to hypertension & Partial vascular renal	5 years
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature H. W. Scheye M.D.

Address H. W. SCHEYE, M. D. Date signed 3/14
3821 EDMONDSON AVE.
BALTIMORE 29, MD.

Spec.—8-16-39—L. F. S.—100 Blks.

Anna Beres

G38372 HEALTH DEPARTMENT—CITY OF BALTIMORE G38372

CERTIFICATE OF DEATH 937

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2526 Fleet ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Beres

(a) RESIDENCE NO. 2526 Fleet ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislaus Beres

6 DATE OF BIRTH (month, day, and year) July 26, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	13 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Biedronski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Edward Beres

(Address) 2526 Fleet St.

15 Filed 1 4 1946 19 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1946

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 19 46 to March 11 19 46

that I last saw h[illegible] alive on March 10 19 46

and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:

Hypertension Cardio Vascular Disease

Chronic Cholecystitis

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Antoni Slawinski M. D.

19 (Address) 2529 Eastern ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	3/15 19 46
20 UNDERTAKER John M. Weber 401	ADDRESS E. Chester St.

BALTIMORE CITY HEALTH DEPARTMENT ✓ × G38373

G38373 CERTIFICATE OF DEATH 164c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Thistle Rd. near Frederick Rd. (If no street, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold C. Care

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband~~ or wife Elsie G. Care

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/1907

8. AGE: Years 39 | Months | Days 8 | If less than one day hr. min.

9. Birthplace Lebanon, Penna. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jonathan C. Care
13. Birthplace Pa.

MOTHER
14. Maiden Name Medessia M. Sheeler
15. Birthplace Pa.

16 (a) Informant Mrs. Elsie G. Care
(b) Address Thistle Rd. Catonsville, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory Reading, Pa.
Location Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 (a) MAR 14 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946 at 11 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shotgun wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Between 9 & 10:45 A. M.
(b) Where did injury occur? Thistle Rd. near Frederick Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self

23. Signature Robert L. Fletcher M.D. Medical Examiner.
Date signed March 14 1946

Caution: age is especially important. Physicians: please write the causes of death clearly and legibly.

17208 G38574 Mondorney V 830 G38574

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 183 N Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME William Lee Mondorney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-3-01

8. AGE: Years 44 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Jeremiah Mondorney

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Anderson

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17 46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location A. A. County Md.

18 (a) Funeral director Mrs. Roberta E. Fluitt

(b) Address 1129 N. Caroline St.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams Registrar

MAR 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946 at 7 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to March 13 1946 and that I last saw him alive on March 13 1946.

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip A. Tumulty M.D.

Address Johns Hopkins Hospital Signed March 19 46

X Tumulty

G38375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G38375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwards Apts No 10
(c) Hospital or institution: 847 Whitelock St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Ott

3 (b) If veteran, name war

3 (c) Social Security Account No. 085-07-0512

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 8, 1910

8. AGE: Years	Months	Days	If less than one day
35	3	5	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Publisher

FATHER
12. Name Jack Ottenheimer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Clara Bussy
15. Birthplace New York City

16 (a) Informant Mary Ott
(b) Address Edwards Apts No10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAR 15 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 10.00

20. DATE OF DEATH March 13 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946 to Mar 15 1946, and that I last saw him alive on Mar 13 1946

Immediate cause of death	Duration
Anemia	2 days
Due to Hodgkins Disease	8 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Weiman M.D.
Address 3900 Dorchester Rd Date signed 4-15-46

VS 150

G38576 HEALTH DEPARTMENT—CITY OF BALTIMORE G38576

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 N Collington Ave St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... da. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... da.

2. FULL NAME Dora Caplan

If U. S. Veteran specify WAR .....

(a) Residence: No. 133 N. Collington Ave St. 6-3 Ward. .....

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Late Joseph

6. DATE OF BIRTH (month, day, year) 1866

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Russia

FATHER

13. NAME Joseph Kaup.

14. BIRTHPLACE (city or town) (State or country) Russia

MOTHER

15. MAIDEN NAME Leah ?

16. BIRTHPLACE (city or town) (State or country) Russia

17. INFORMANT A M. Caplan

(Address) 3702 Dorchester Road.

18. BURIAL, CREMATION, OR REMOVAL

Place Holser Randalls Cem. Date March 15 1946

19. UNDERTAKER Sol Levinson & Bro

(Address) 1124-26 W Baltimore

DATE RECD MAR 15 1946 19 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 14, 1946

22. I HEREBY CERTIFY, That I attended deceased from Dec. 1945 to March 14, 1946

I last saw her alive on March 14, 1946. Death is said to have occurred on the date stated above, at 6:15 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertension	1936
Cerebral Hemorrhage	1946 (Mar 14)

Other contributory causes of importance

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury — 19..

Where did injury occur? —

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Benjamin B. Mora, M. D.

(Address) 448 N. LUZERNE AVE.

VS 3

OCCUPATION is very important. See instructions on back of certificate.

638377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

638377

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2043 Hollins St
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2043 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith (Edytha) P. Delcher

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Earl F. Delcher

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 3-17-1906

8. AGE: Years 39 | Months 11 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business At Home.

FATHER
12. Name Sherman Nevin
13. Birthplace Md

MOTHER
14. Maiden Name Unknown Flynn
15. Birthplace Md

16 (a) Informant Mr. Earl F. Delcher
(b) Address 2043 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) Date received (month) (day) (year) Huntington Williams, M.D. Registrar

MAR 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1946, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to March 1946, and that I last saw h.e alive on March 12 1946

	Duration
Immediate cause of death: Pulmonary Tbc	1 yr
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Sulinski M. D.
Address 3/13/46 Date signed

G38378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G38378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Hollins Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. Clement Leslie Gaskins

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife Mrs. Katie Gaskins KATHERINE — 6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) JAN. 8, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	6	— hr. ..... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business —

FATHER
12. Name Sylvester Gaskins
13. Birthplace Ohio

MOTHER
14. Maiden Name Lucy Robb
15. Birthplace Ohio

16 (a) Informant Mrs. Katie Gaskins
(b) Address 1701 Hollins St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto. Md.

18 (a) Funeral director Geo. E. Boyer Jr
(b) Address 1512 Hollins St

19 MAR 15 1946 (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24, 1946 to March 14, 1946 and that I last saw him alive on March 14, 1946.

Immediate cause of death Coronary-Sclerosis — Duration
Heart Disease.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. S. Speed III
Address Union Mem. Hosp. Date signed 3/14/46

X

G38379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √93E

G38379 Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 Carey St.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Carey St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Nutter

3 (b) If veteran, name war: Wordwar one

3 (c) Social Security Account No. 215-09-9729

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lillian Nutter

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 20, 1894

8. AGE: Years 51 | Months 7 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Wicomico Co. Md
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Cochran Hill Co.

FATHER
12. Name George Henry Nutter
13. Birthplace Wicomico Md

MOTHER
14. Maiden Name Mary Ellen Catlin
15. Birthplace Wicomico Co. Md

16 (a) Informant Mrs. Bessie Anderson
(b) Address 824 Carey St.

17 (a) Burial (b) Date thereof 3-16-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location Anne Arundel Co. Md

18 (a) Funeral director Mrs. Frances H. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Date received MAR 15 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-1941 to 3-12-1946 and that I last saw h... alive on ... 19...

Immediate cause of death: Myocarditis — Duration: 1 yr 2 mos

Due to: — Duration: Duke 2 yrs

Due to: — Duration:

Other Conditions: Bronchial asthma — Duration: Since 1919

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Laufers M. D.

Address 1029 N. Stricker Date signed 3-14-46

X

G38380 99675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

G38380 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Lloyd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Banks or August Behnke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1884

8. AGE: Years	Months	Days	If less than one day
61	11	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business

FATHER
12. Name August Banks
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Stockfish
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 16/46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lloyd Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 MAR 15 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1946 at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 3 1946 to Mar. 11 1946 and that I last saw h[illegible] alive on Mar. 11 1946.

Immediate cause of death Kidney obscure and pyonephrosis — Duration

Due to Arteriosclerosis org.

Due to

Other Conditions Cirhosis Hepatitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Pyonephrosis, Cirhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerniger M.D.
Address Baltimore City Hosp Date signed 3-14-46

VS 150

G38381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 101

G38381 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 2 d

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 S. ANN Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jean Doris Majka

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 6, 1945

8. AGE: Years | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Anthony Majka
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Josephine Beczkowska
15. Birthplace Baltimore, Md.

16 (a) Informant Anthony Majka
(b) Address 17 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director M. A. C. Associates
(b) Address Lombard & Ann Sts.

19 MAR 15 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946 at 8 30 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Mesenteric lymphadenitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed March 14, 1946

VS 151

38382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 38382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. for Women of Md. 15

2: USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Keyworth Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Goldenson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/14/46

8. AGE: Years	Months	Days	If less than one day
—	—	—	— hr. 13 min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Barney Levin Goldenson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ida Ruth Foreman
15. Birthplace Balto., Md.

16 (a) Informant Ida Ruth Goldenson
(b) Address 2805 Keyworth Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 14 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 15 1946 (Date rec'd by registrar) (Signature of registrar) Huntington Williams M.D.

VS 150

3367

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/46 1946, at 3 42 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1946, to 3/14 1946, and that I last saw him alive on 3/14 1946

Immediate cause of death Bilateral atelectasis, congenital

Duration
13 min.,

Due to Prematurity - 24 wks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Eaton, M.D.

Address Hosp. for Women of Md. Date signed 3/16/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G38383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Clarkentorely Terr
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Corgan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Corgan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Vienna
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Morton
13. Birthplace Vienna

MOTHER
14. Maiden Name Naomi
15. Birthplace Vienna

16 (a) Informant Hoyt Quesada
(b) Address

17 (a) Burial (b) Date thereof 3-15-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fernwood Rd.

18 (a) Funeral director Jack Lewis Loy
(b) Address 1439 E Baltimore St

19 MAR 15 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 March 1946 at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 March 1946 to 3/14/46 19, and that I last saw h-im alive on 3/14/46 19

Immediate cause of death	Duration
Myocardial Failure	
Due to Coronary Heart Disease	
Due to	
Other Conditions Benign Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 3/12/46

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Hollander M. D.

Address Sinai Hospital Date signed 3/14/46

VS 150

G38384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

Registered No. G38384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: Sp Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Lloyd St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Flora T Thomas

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Frederick Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1898

8. AGE: Years	Months	Days	If less than one day
47	6	30	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gus Belnke
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Stockfish
15. Birthplace Baltimore, Md

16 (a) Informant Frederick Thomas
(b) Address 34 Lloyd St.

17 (a) Burial (b) Date thereof 3/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) MAR 15 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1946 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1946 to March 14 1946 and that I last saw h[illegible] alive on March 14 1946.

Immediate cause of death.	Duration
Peritonitis	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H O Janssaney M. D.
Address [illegible] Date signed 3/14/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1463

Registered No. 638385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3522 - 6th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3440 - 2nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Essex

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Susanna M. Essex

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1874

8. AGE: Years 71 | Months 6 | Days 29. | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Labour Retired

11. Industry or business

FATHER 12. Name Richard Essex

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Emma C Kemp

15. Birthplace Baltimore Md

16 (a) Informant Harry Essex

(b) Address 3522 - 6th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Irvington Md

18 (a) Funeral director Fulton Funeral Home

(b) Address 1219 E Cold St

19 (a) (Date received by local registrar) MAR 15 1946 (b) Huntingtown Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946, at 8.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1946 to Mar. 13 1946, and that I last saw him alive on Mar. 11, 1946

Immediate cause of death: Carcinoma of the stomach — Duration

Due to: —

Due to: —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M.D.

Address 1226 Hanover St Date signed 3/16/46

VS 150

X

G38386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G38386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 Tremont Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N Tremont Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura Virginia Blucher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Laura E. Blucher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1866

8. AGE: Years	Months	Days	If less than one day
80	0	21	hr. min.

9. Birthplace Howard Co. Md
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Thomas Wells
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name E. Elley
15. Birthplace Howard Co. Md.

16 (a) Informant Mrs Catherine Weber
(b) Address 16 N. Tremont Rd

17 (a) Burial (b) Date thereof 3/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b) Huntington Williamsport Md

MAR 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13th 1946 at 12:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to Mar 13 1946 and that I last saw h.. alive on Mar 12 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alston H. Chamberlain M. D.
Address 4209 Hood Ave Date signed 3/13/46

G38387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G38387

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S. Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 S. Eaton st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie Watson
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb 20th 1869

8. AGE: Years	Months	Days	If less than one day
77 79	0	24	hr. min.

9. Birthplace Ireland
(Town, county and state)
10. Usual Occupation Track Foreman
11. Industry or business Penna R. R.

FATHER
12. Name William Watson
13. Birthplace Ireland

MOTHER
14. Maiden Name Nora Castello
15. Birthplace Ireland

16 (a) Informant Mrs. Annie Watson
(b) Address 901 S. Eaton st.

17 (a) Burial (b) Date thereof 3/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 15 1946 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1946 at 9 45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1946 to Mar 14 1946 and that I last saw him alive on March 14 1946.

Immediate cause of death PULMONARY EDEMA — Duration 3/14/46

Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE — ? ?

Due to

Other Conditions CEREBRAL HEMORRHAGE — 3 YRS. AGE.
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

—

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jeff F. Arenz
Address 209 W. Chesty St Date signed 3/15/46

X

G38388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38388 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Roslyn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilith Fait Eiser

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John H. Eiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 1, 1866

8. AGE: Years 79 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: John Fait
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Amelia Hildebrandt
15. Birthplace: Unknown

16 (a) Informant: Mr. John B. Eiser
(b) Address: 531 Nottingham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves.

19 (a) MAR 15 1946 (Must not be filled by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1937 to Mar 14 1946 and that I last saw h[illegible] alive on Mar 14 1946

	Duration
Immediate cause of death: Coronary Thrombosis 2nd Attack	Immediate
Due to: Generalized Arteriosclerosis	Indefinite
Due to:	
Other Conditions: Chronic Myocarditis	Indefinite

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 3727 N. Charles St. Date signed Mar 15 46

VS 150

G38389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G38389 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 248 Albemarle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonio Sergi

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none
4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maria Sergi
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 7 1878
8. AGE: Years 68 | Months | Days 6 | If less than one day hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Ice dealer
11. Industry or business Self

FATHER
12. Name Sebastiano Sergi
13. Birthplace Italy

MOTHER
14. Maiden Name Pauline Sergi
15. Birthplace Italy

16 (a) Informant Maria Sergi Wife
(b) Address 248 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Marley St.

19 (a) [illegible] (b) Huntington Williams, M.D.

MAR 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13- 1946 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1941 to 3-13- 1946 and that I last saw h— alive on 3/12/ 1946

Immediate cause of death Hemiplegia-

Due to Hemiplegia

Due to cerebral hemorrhage ?
Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 8 yrs 3 mo 12 days ? .

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Donato

Address Medical arts Bldg Date signed 3/13/46 M. D.

G38390

488987.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G38390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 ↑ 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lyathea Harvey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	✓

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-78

8. AGE: Years	Months	Days	If less than one day
67	3	14	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Augusta Brown
13. Birthplace Va.

MOTHER 14. Maiden Name Georgian Butler
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1100 Brookfield Ave Baltimore, Md.

MAR 15 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH March-12 1946 at 7.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-25 1946 to March-12 1946 and that I last saw h[er] alive on March-12 1946.

Immediate cause of death	Duration
Acidosis	
Due to Diabetes mellitus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philip Turnbull Johns Hopkins Hosp. Balto. M. D. Date signed 3/16/46

VS 150

G38391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G38391 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs. 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. GAY ST. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MYLES BRODERICK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 28, 1897

8. AGE: Years	Months	Days	If less than one day
48	9	14	hr. min.

9. Birthplace MIDLAND, MD. (Town, county, and state)
10. Usual Occupation ORDERLY
11. Industry or business HOSPITAL

FATHER
12. Name WILLIAM BRODERICK
13. Birthplace MIDLAND, MD.

MOTHER
14. Maiden Name ISABEL THOMPSON
15. Birthplace MIDLAND, MD.

16 (a) Informant MYLES BRODERICK
(b) Address 160 N. GAY ST., BALTO., MD.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/15/46 (month) (day) (year)
(c) Cemetery or crematory
Location Lanaconning, Md.

18 (a) Funeral director Wm. J. Fickus Home
(b) Address Balt. 13, Md.

19 MAR 15 1946 (Date rec'd by Registrar) Washington Hilligoss, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 14 1946, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 14 1946 to MARCH 14 1946 and that I last saw h.im. alive on MARCH 14 1946

Immediate cause of death LOBAR PNEUMONIA — Duration

Due to

Due to

Other Conditions CHRONIC ALCOHOLISM

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hedrick, M.D.
Address Mercy Hospital Date signed 3/17/46

VS 150

For Dr. J.R. Davis, by Howard L. Chaillis, M.D.X

G38392 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G38392

CERTIFICATE OF DEATH √83a

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. Belnord Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME CATHERINE RICHARDSON

If U. S. Veteran specify WAR

(a) Residence: No. 121 N. BELNORD AVE St., 6-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced WIFE of (or) HUSBAND of Hugon

6. DATE OF BIRTH (month, day, year) June 10 — 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	9	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Co. Md.

FATHER

13. NAME Charles Euser

14. BIRTHPLACE (city or town) (State or country) Balto Co. Md

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Balto. Co. Md

17. INFORMANT Catherine Richardson

(Address) 121 N. Belnord Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Mount Park Date 3/18 1946

19. UNDERTAKER John G. Hudson

(Address) 3000 E. Balto St.

20. MAR 15 1946 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) MARCH 14, 1946

22. I HEREBY CERTIFY, That I attended deceased from DECEMBER 1945 to MARCH 14, 1946

I last saw her alive on MARCH 14, 1946 Death is said to have occurred on the date stated above, at 11:30 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
ARTERIOSCLEROSIS	1937
CEREBRAL HEMORRHAGE	FEB. 19 1946
BRONCHOPNEUMONIA	MAR. 13 1946
Other contributory causes of importance:	

Was an operation performed? NO Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury 19

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signed) Benjamin B. Mora M. D.

(Address) 1448 N. Luzerne Ave.

V.S.

MAKE CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered 638393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2711 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wallace H. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0941

4. Sex Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Margaret Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4-1866

8. AGE: Years 79 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace New York

MOTHER
14. Maiden Name Unknown
15. Birthplace New York

16 (a) Informant Louis Moylan
(b) Address 2711 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

MAR 15 1946 (Date received) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1946 at 2-0 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 1 1945 to March 14 1946, and that I last saw h/[illegible] alive on March 13 1946

Immediate cause of death Decompensating arterio-renal vascular disease — Duration 2 wks.

Due to Hypertensive heart disease — 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1101 N. Milton Ave Date signed 3-14-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58D

Registration No. G38394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 N. Broad St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lorraine Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22nd 1935

8. AGE: Years 10 | Months 8 | Days 20 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor Cager
15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-15-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location U.S. Co. Md

18 (a) Funeral director Batson Fraser & Wright

(b) Address 721 Eutaw St

19 (Date rec'd by reg.) MAR 15 1946 [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3.12 1946, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2.27 1946 to 3.12 1946 and that I last saw he alive on 3.12 1946.

Immediate cause of death: acute cardiac failure — Duration

Due to: Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Blair Everett Batson M.D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 3/12/46

VS 150

G38395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G38395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Wilcox st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Wilcox st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nathaniel Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Separated

6 (b) Name of husband or wife Lottie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1892

8. AGE: Years	Months	Days	If less than one day
54 Yrs	1	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Carrie Williams
(b) Address 1006 Wilcox St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County

18 (a) Funeral director Mrs. Robert A. Elliott & Dyer
(b) Address 1129 N. Carolina St.

19 (Date rec'd by registrar) MAR 15 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14. 1946, at 2.25 P.M.

21. I certify that I took charge of the remains described above, held an Inq. - Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension, Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarski M.D.
Medical Examiner.
Date signed 3-16-46

VS 151

Write the causes of death clearly and legibly. Physicians: please write plainly. Do not use abbreviations.

G38396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38396

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Md. General Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11dy.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore #2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 Abermarle Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Lithuania

3 (a) FULL NAME Adam Urban

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband~~ or wife Rose Urban

6 (c) If alive, give age 1882 years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1880

8. AGE: Years	Months	Days	If less than one day
63 ~~65~~	2	20	hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Urban
13. Birthplace Lithuania

MOTHER
14. Maiden Name Anna (?)
15. Birthplace Lithuania

16 (a) Informant Rose Urban
(b) Address 30 Abermarle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kaminska
(b) Address 60 E. Cash. Blvd

19 (a) Date received by registrar MAR 15 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1946 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1946 to 3/13 1946 and that I last saw h.. alive on 3/13 1946

Immediate cause of death Heart failure

Due to following Chole-cystectomy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/5/46

Major findings of operation: Chole cystitis

of autopsy:

Duration: 8 dys.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Phillips M. D.
Address Madison & Linden Ave Date signed 3/13/46

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 038397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Henrietta Diegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theodore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1900

8. AGE: Years 45 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Husband Theodore

(b) Address 707 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 18 46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wilhorn & Sons

(b) Address 1214 Pennsylvania Ave

19 (a) MAR 15 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15 1946, at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946, to Mar 15 1946, and that I last saw her alive on Mar 15 1946.

Immediate cause of death Myocardial Degeneration

Due to Carcinoma of the Uterus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel Hope Jr. M. D.

Address St Agnes Hospital Date signed 3/15/46

VS 150

G38398 — BALTIMORE CITY HEALTH DEPARTMENT — G38398 Registered No.

CERTIFICATE OF DEATH 1936

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Huntington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Jones.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28 1901

8. AGE: Years 35 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Wilbur H. Jones
13. Birthplace Md

MOTHER — 14. Maiden Name Sarah Matthews
15. Birthplace Pa

16 (a) Informant Prof Jones
(b) Address Lynchburg

17 (a) Removal (burial, cremation, or removal) (b) Date thereof 3/16/36 (month) (day) (year)
(c) Cemetery or crematory Stewartstown
Location Stewartstown Pa

18 (a) Funeral director Wilbur Cook Co
(b) Address 1214 E. Baltimore St

19 (a) Huntington Williams, Md. Registrar

MAR 15 1936

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13- 1936, at 9 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Howard J. Mellon M.D.
Medical Examiner.
Date signed 3-14-36

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38399 N

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Reg. No. G38399

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Hunterington
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Georges Grisez

3 (b) If veteran, name war	3 (c) Social Security Account No.
D	

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	W	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31. 1884

8. AGE: Years	Months	Days	If less than one day
61	11	13	hr. min.

9. Birthplace Paris, France
(Town, county, and state)
10. Usual Occupation Clarinetist
11. Industry or business Balt Symphony Orchestra

FATHER
12. Name Leon Grisez
13. Birthplace France

MOTHER
14. Maiden Name Corbin
15. Birthplace France

16 (a) Informant Mrs Marie Grisez
(b) Address 2649 Huntington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46
(month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilhom Bros
(b) Address 1217 E Cold St

19 MAR 15 1946 (b).....
(Date rec'd by local reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/46 19..., at 9:25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 3/15/46

VS 151

G38 Dr. Machen
6304 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54a

Registered No. G38100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3167 Elmora Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3167 Elmora Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irving Burton West

3 (b) If veteran, name war
3 (c) Social Security Account No. 150-10-3254

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Dorothy B. West
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1916

8. AGE: Years	Months	Days	If less than one day
29	9	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Sparrows Point

FATHER
12. Name Ernest West
13. Birthplace Md.

MOTHER
14. Maiden Name Hattie West
15. Birthplace Md.

16 (a) Informant Mrs. Dorothy B. West
(b) Address 3167 Elmora Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

MAR 15 1946
(Date rec'd by registrar)

Thursday [illegible]

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1946 to 3/14 1946 and that I last saw h[illegible] alive on 3/11 1946

Immediate cause of death: BRAIN TUMOR (medulloblastoma of cerebellum.) — Duration 1 mo. +
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation July 27 - 1945
Major findings of operation: Johns Hopkins Hosp. (see above for pathological diagnosis)
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Machen M.D.
Address 6304 Belair Rd Date signed 3/17/46

X Machen

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38401 — BALTIMORE CITY HEALTH DEPARTMENT — G38401 Registered No.

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Urban Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Urban Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C. Walters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emma F. Schmidtmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1880

8. AGE: Years	Months	Days	If less than one day
65	7	30	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John
13. Birthplace Baltimore

MOTHER
14. Maiden Name not known
15. Birthplace Baltimore

16 (a) Informant Wife
(b) Address 1221 Urban Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MAR 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1946 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Myocardosis — Duration

Due to Arteriosclerotic heart disease

Due to Arteriosclerosis

Other Conditions Prostatic hypertrophy & urinary obstruction

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Gould M. D.
Address 142 East ave 24 Date signed 3-15

G38402

JL - 98628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G38402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 27
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Westley Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1883

8. AGE: Years	Months	Days	If less than one day
62	8	20	hr. min.

9. Birthplace Fla.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eli
13. Birthplace Fla.

MOTHER
14. Maiden Name Jane Jones
15. Birthplace Fla.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Eutaw St.

19 (a) MAR 15 1946 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1946 to Mar. 14 1946, and that I last saw h im alive on March 14 1946

Immediate cause of death — Duration

Carcinoma of Stomach
Due to Metastasis to Larynx
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature T. P. Jennings M. D.
Address Baltimore City Hosp Date signed 3-15-46

VS 150

638403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

638403

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2531 E Oliver St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 E Oliver
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Doersch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Geo J Doersch
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 23 1860

8. AGE: Years 86 | Months 10 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Nauman
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Selma Ford
(b) Address 2531 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location City

18 (a) Funeral director Wilbert Funeral Home
(b) Address 20 E Orleans St

19 (a) MAR 15 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1946 to March 13 1946 and that I last saw h[illegible] alive on March 11 1946.

Immediate cause of death	Duration
Cancer Mycardeta	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death.)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm D Schmidt
Address 701 N. Edmondson Ave Date signed 3/16/46 (M.D.)

G38404 JL - 98813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G38404

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 E. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Jeanette E. Levy

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 8, 1946

8. AGE: Years: 0 | Months: 2 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER — 12. Name: Louis Mose Levy
13. Birthplace: Md.

MOTHER — 14. Maiden Name: Roxie May Ingle
15. Birthplace: Va.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director: Philip Herwig Sons
(b) Address: 2024 Orleans St

19 (a) Date received by Local Registrar: MAR 15 1946 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1946, at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25, 1946 to Mar. 14 1946, and that I last saw him alive on Mar. 14 1946

Immediate cause of death	Duration
Heart block complete (clinical and by electrocardiogram)	
Due to	
Due to	
Other Conditions: Atelectasis left lower lobe, aspiration (Include pregnancy within 3 months of death)	

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: George L Palmer M. D.
Address: Baltimore City Hosp Date signed 3-15-46

G38405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G38405 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hospital 19 [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 W. Mulberry st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Sharp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1928

8. AGE: Years	Months	Days	If less than one day
17 Yrs.	11	1	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wm. Sharp
13. Birthplace Franklin, Va.

MOTHER
14. Maiden Name Fanny White
15. Birthplace Franklin Va.

16 (a) Informant Fanny White
(b) Address 1413 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March (month) (day) (year)
(c) Cemetery or crematory W. Ft Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Robinson St.

19 (a) MAR 15 1946 (b) by Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-1946, at 1 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25 T 5

(a) Date of injury Between 3-12-46 & 3-13-46 at M.
(b) Where did injury occur? Harbor Waters, Standard Furniture Co. Curtis Bay
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no ?
(d) Means of injury Found drowned.

23. Signature Robert La Gorce M.D. Medical Examiner.
Date signed March 13 1946

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38406 BALTIMORE CITY HEALTH DEPARTMENT G38406

CERTIFICATE OF DEATH 1570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N Schroeder
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeminie Lee Jackson.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1946.

8. AGE: Years	Months	Days	If less than one day
		21/23	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Jackson.
13. Birthplace Darlington, S.C.

MOTHER
14. Maiden Name Maude Williams.
15. Birthplace Darlington, S.C.

16 (a) Informant Harry Jackson
(b) Address 104 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams,
(b) Address 322 N. Schroeder St.

MAR 15 1946 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/46 1946, at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1946 to 3/14 1946, and that I last saw h[illegible] alive on 3/14 1946.

Immediate cause of death Respiratory failure — Duration

Due to Aspiration pneumonia

Due to Congenital defect of G.I. tract

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3/14
Major findings of operation: Congenital defect of G.I. tract
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. H. Robinson M.D.
Address U.S.W. Hospital Date signed 3/15

VS 150

Fleets ✓ G38407

G38407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 McCulloch St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country —

3 (a) FULL NAME Frank Fleets

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 22 1899

8. AGE: Years 46 | Months 5 | Days 20 | If less than one day — hr. — min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Arthur Fleets
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Davis
15. Birthplace Virginia

16 (a) Informant —
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location .....

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) MAR 15 1946 (Date received by registrar) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12/46 19 , at 335 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1946 to 3/12 1946 and that I last saw h[illegible] alive on 3/12 1946

Immediate cause of death Uremia — Duration 1 wk

Due to Chronic Colom. Nephritis — Duration 2 yr.

Due to ..... — Duration .....

Other Conditions Chronic Passive Congestion — Duration ? yr.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature [signature] Kelly Jr

Address Mercy Date signed 3/13 M. D.

VS 130

G38408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 D

G38408 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Patapsco Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4111 Hyden Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Youngbar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 25, 1945

8. AGE: Years	Months	Days	If less than one day
	7	17	20 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Joseph G. Youngbar
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice K. CARPER.
15. Birthplace BALTO. MD.

16 (a) Informant FATHER.
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof March 17 46 (month) (day) (year)
(c) Cemetery or crematory Holy CROSS
Location A.A. Co.

18 (a) Funeral director Bernard G. Keale
(b) Address 171 6 West St

19 (a) MAR 15 1946 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1946, at 12 15 P M

21. I certify that I took charge of the remains described above, held an Inquest and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to gastric contents

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 14, 1946 25/5 16 A M
(b) Where did injury occur? 4111 Hyden Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury choked on gastric contents

23. Signature Roland Lee Gutstein M.D.
Medical Examiner.
Date signed March 14 1946

Physicians: please write the causes of death clearly and legibly. The age is especially important.

JL - 72188 C38409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131A

Registered No. C38409

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-0-12
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 N. Central Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22 ? ? 1863

8. AGE: Years	Months	Days	If less than one day
80 ?	?	? 22	hr. min.

9. Birthplace Baltimore Co., (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Ben Waters
13. Birthplace Balto. Co.,

MOTHER
14. Maiden Name Mandy ?
15. Birthplace Balto. Co.,

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 16 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1413 E. Preston St

19 (a) Date MAR 1 1946 Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 46 at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1, 1942 to Mar. 13 19 46 and that I last saw h alive on Mar. 13 19 46

Immediate cause of death	Duration
Respiratory failure	
Due to arteriosclerotic Heart Disease	
Due to Generalized arteriosclerosis	
Other Conditions Nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation none
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. S. Jenyon M. D.
Address Baltimore City Hall Date signed 3-14-46

JL - 98961 G38410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G38410

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Duncan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Simms

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-4437

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Div.

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1905

8. AGE: Years	Months	Days	If less than one day
40	6	3	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Sparrow
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16 1946 (month) (day) (year)
(c) Cemetery or crematory St. Pauls R.C. Reformed
Location Caroline and
18 (a) Funeral director Wendell Whipple
(b) Address 312 S. Highland Ave
19 (a) Date received MAR 15 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946, at 6:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1946 to Mar. 13 1946, and that I last saw h er alive on Mar. 13 1946

Immediate cause of death: Carcinoma of Splenic Flexure of Colon with Multiple Metastases — Duration: unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-5-46

Major findings of operation: Ca Diag

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank E. Butterworth M. D.
Address Balt. City Hosp. Date signed 3-13-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38411 ✓ G38411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1054 Bristol Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald C. Wilkie

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1 1946

8. AGE: Years 0 | Months 1 | Days 14 | If less than one day 6 hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Charles J. Wilkie
13. Birthplace Greenwell S.C.

MOTHER 14. Maiden Name Clavice D. McLeod
15. Birthplace Jonesboro, N. C.

16 (a) Informant Rescuda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof 3/ (month) (day) (year)

(c) Cemetery or crematory
Location Sanford, N. C.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie Md.

MAR 15 1946 (Date rec'd by Registrar) Huntington Williamsport Pa. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 14 1946 at 4 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14 1946 to Mar. 14 1946 and that I last saw h. alive on Mar. 14 1946

Immediate cause of death: Intestinal Obstruction — Duration

Due to volvulus

Due to

Other Conditions peritonitis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy volvulus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard E. Dorrance

Address Hopkins Hospital Date signed 3/15/46

VS 150

G38412 BALTIMORE CITY HEALTH DEPARTMENT G38412

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2552 W. Pratt Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2552 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Ross

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-09-0968

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ella A. Ross
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 8, 1884 (1864)

8. AGE: Years 62 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Samuel Kirk & Co.

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Reese
15. Birthplace Md.

16 (a) Informant Ella A. Ross
(b) Address 2552 W. Pratt Street

17 (a) Burial (b) Date thereof 3-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

MAR 15 1946
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1946, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1946, to Mar. 13 1946, and that I last saw h[illegible] alive on Mar. 13 1946

	Duration
Immediate cause of death: Myocarditis	3 Months
Due to: Generalized Arteriosclerosis	3 Years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hans Hate, M. D.
Address 517 Scott St. Date signed 3/14/46

G38413

AB-99789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Robb

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife: Wallace Robb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3-1860

8. AGE: Years	Months	Days	If less than one day
85	10	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

Unable to obtain further information

FATHER 12. Name Readon Crocken
13. Birthplace Balto Md

MOTHER 14. Maiden Name Catherine Smith
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 16 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1946, at 11.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1946 to 3-14 1946, and that I last saw her alive on 3-14 1946

Immediate cause of death	Duration
Bronchopneumonia	
arteriosclerosis, myocarditis	
Due to: Pyelonephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 3-15-46

VS 150

G38414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G38414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madeira Ave
(c) Hospital or institution: Maryland General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 E. 30th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Blanche Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband: Walter E. Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25th 1877

8. AGE: Years 68 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: John H. Marquette
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Augusta C. Leonard
15. Birthplace: Balto Md.

16 (a) Informant: James Marquette
(b) Address: 803 Venable Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

MAR 16 1946 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1946 at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 12th 1946, to March 15th 1946, and that I last saw her alive on March 15th 1946.

Immediate cause of death	Duration
Heart failure	
Due to: Bronchopneumonia	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: C. C. Jonsiby M.D.
Address: Maryland G. Hospital Date signed 3/15/46 M. D.

VS 150

G38415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G38415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dominic Nacin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Nov 20 1913

8. AGE: Years 32 | Months 3 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Shamokin, Pa. (Town, county, and state)

10. Usual Occupation Window Cleaner

11. Industry or business Queen City Co.

FATHER
12. Name Stephen Nacin
13. Birthplace Czecho-Slovakia

MOTHER
14. Maiden Name Mary Maniste
15. Birthplace Czecho-Slovakia

16 (a) Informant Marie Mihal
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 16 1946 Registered by [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946 at 6 45 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Contusion of brain
Intracranial hemorrhage.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-46 9:30 A.M.
(b) Where did injury occur? Hearst Bldg.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from 3rd floor

23. Signature Benedict Shatarlie M.D.
Medical Examiner.
Date signed March 15, 1946.

VS 151

X

G38416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G38416

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Gorman Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Gorman
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George E. Amey Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sophia Amey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9th 1880

8. AGE: Years	Months	Days	If less than one day
65	8	5	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Retired Steam fitter
11. Industry or business H. E. Crook Co.

FATHER
12. Name William E. Amey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Balto. Md.

16 (a) Informant Mrs Sophia Amey
(b) Address 33 Gorman Ave

17 (a) Burial (b) Date thereof 3/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Odar Hill
Location a.a. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

MAR 16 1946
(Date received by Registrar)

Huntington Williams M.D.
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1946, at 5-50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944 to March 14 1946, and that I last saw him alive on March 14 1946,

Immediate cause of death	Duration
Cerebral Hemorrhage.	1 week.
Due to Arteriosclerosis Hyper - tension.	5 yrs
Due to	
Other Conditions Arteriosclerotic type Contributory	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Michael M. D.
Address March 15 1946 Date signed

2 yrs of Hypertension and

X

VS 150

G38424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33

G38417
Registered No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd. & Herring Run.
(c) Hospital or institution: Lydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Oakley (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Ann Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 6 1942

8. AGE: Years 2 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Oakley, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Hall
13. Birthplace Hydes, Md.

MOTHER
14. Maiden Name Catherine Quade
15. Birthplace Hydes, Md.

16 (a) Informant Hereby Hall
(b) Address Oakley Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4 1946 (month) (day) (year)
(c) Cemetery or crematory Lazarus Point Cemetery
Location Bush Wood Md

18 (a) Funeral director Jos. C. Spalding
(b) Address Leonardtown Md

19 (a) 2-4-'46 (b) R. M. Palmer Registrar

MAR 16 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1946, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1946 to Mar. 2 1946, and that I last saw h[illegible] alive on Mar. 2 1946.

Immediate cause of death Influenza Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hezekiah Spragins M.D.
Address Lydenham Hosp. Date signed 3-2-46

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G38418 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. J. MERTZ

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Blanche Mertz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 8, 1889

8. AGE: Years 56 | Months 8 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Meat Business

11. Industry or business: Self

FATHER
12. Name: Frank Mertz
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth Tanner
15. Birthplace: Cincinnati, Ohio

16 (a) Informant: Mrs. Blanche Mertz
(b) Address: 3716 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAR 16 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1946, at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/1946 to 3/14/1946 and that I last saw alive on 3/14/46

Immediate cause of death	Duration
General debility	2 mos.
Due to Carcinomatosis	2 mos.
Due to Primary carcinoma of bladder	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Welk M. D.
Address 4100 Edmondson Ave. Date signed 3/15/46

VS 150

G38419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 McElderry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WINIFRED H. WILSON

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or ~~wife~~: Edgerton G. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 9, 1867

8. AGE: Years: 79 | Months: 0 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Deals Island Md. (Town, county, and state)

10. Usual Occupation: Home

11. Industry or business

FATHER
12. Name: Eldridge Windson
13. Birthplace: Deals Island Md.

MOTHER
14. Maiden Name: Mary Webster
15. Birthplace: Deals Island Md.

16 (a) Informant: Mr. Edgerton R. Wilson
(b) Address: 515 Overbrook Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/46 (month) (day) (year)
(c) Cemetery ~~xxxxxxxxx~~ Deals Island Md.
Location

18 (a) Funeral director: Wm. J. TICKNER & SONS, INC.
(b) Address: North & Pa Aves Baltimore Md.

19 (a) MAR 16 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 3/14 1946, and that I last saw h[illegible] alive on 3/10 1946.

Immediate cause of death	Duration
Coronary Thrombosis	2
Uremia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. A. Wolgan M. D.
Address 6 E. 22nd St. Date signed 3/15/46

VS 130

MAGdalene

G38420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G38420 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: St Agnes Hospital
(a) Baltimore City, Maryland ✓
(b) Street address Wilkens Ave 2900
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltcity.
(c) City or town Mt. Hope Retreat
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Magdalene Schauff.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 18 1866

8. AGE: Years	Months	Days	If less than one day
79	7	25	24 hr. — min.

9. Birthplace Penna. (Phila.) (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name Louis Schauff
13. Birthplace Prussia

MOTHER
14. Maiden Name Julieanna Drea
15. Birthplace Germany

16 (a) Informant Mt Hope Retreat
(b) Address (city)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-46 (month) (day) (year)
(c) Cemetery or crematory St Matthews
Location Montgomery Co Penna

18 (a) Funeral director Sullivan Mooney Co.
(b) Address 108 W Monroe.

19 (a) MAR 16 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946, to Mar 15 1946, and that I last saw h[illegible] alive on March 15 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Degenerative Cardio Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. A. Cleary, M.D.
Address Wagner Hospital Date signed 3/17/46

X

G38121 489176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G38121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George H. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Black.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-46

8. AGE: Years	Months	Days	If less than one day
	1	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name George H. Johnson
13. Birthplace Md.

MOTHER 14. Maiden Name Mary P. Haggett
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School MAR 15 1946
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) MAR 16 1946 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March-5-1946, at 8.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1946 to March-5 1946, and that I last saw h.im alive on March-5 1946.

Immediate cause of death Respiratory failure — Duration

Due to Prematurity & disorder

Due to Disorder

Other Conditions 2 Aspirations

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Dorman M.D.
Address Johns Hopkins Hosp. Date signed 3/16/46

3368

VS 150

G38422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38422

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 W. Fayette st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 W. Fayette st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ophelia L. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Lewis Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 1882

8. AGE: Years 63 Months 11 Days 12 If less than one day hr. min.

9. Birthplace Warsaw Va (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name John Bailey
13. Birthplace Richmond Co. Va

MOTHER
14. Maiden Name Lewis
15. Birthplace Richmond Co Va

16 (a) Informant Polly Douglas.
(b) Address 906 W Fayette

17 (a) Motoring (Burial, cremation, or removal) (b) Date thereof March 17 46 (month) (day) (year)

(c) Cemetery or crematory Warsaw
Location Richmond Co. Va.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) MAR 16 1946 (Registrar's Office) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 1946 at 10 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to Mar 13 1946 and that I last saw h[illegible] alive on Mar 13 1946

Immediate cause of death Uraemia — Duration

Due to Hypertension — Duration

Due to — Duration

Other Conditions Chronic Myocarditis — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1111 Sea Date signed 3/15/46

Dr. Singewald
1613 E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 638423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1740 Gorsuch Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 Gorsuch Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Charles R. J. Flayhart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary T. Flayhart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1876

8. AGE: Years 69 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles M. Flayhart
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Curry
15. Birthplace Md.

16 (a) Informant Mrs. Mary T. Flayhart
(b) Address 1740 Gorsuch Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Cathdral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAR 16 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1946 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13, 1945 to 3-16, 1946 and that I last saw him alive on 3-14- 1946

	Duration
Immediate cause of death: Coronary occlusion.	1 day
Due to: Arteriosclerosis	4 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas R Singewald M. D.
Address 1613 E. North Ave. Date signed 3-16-

X

G38424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G38424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elva S. Gill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Thomas A. Gill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1884.

8. AGE: Years	Months	Days	If less than one day
62	1	25 28	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Moses C. Gosnell
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Thomas A. Gill
(b) Address 126 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd.

18 (a) Funeral director Harry H. Lutkyce.
(b) Address 4101 Edmondson Ave.

(c) MAR 16 1946 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1946, to 3-14 1946, and that I last saw h alive on 3-14 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	1/2 day
Due to Hypertensive cardio-vascular disease	7
Due to	
Other Conditions Arterio Sclerosis & ulceration of left foot	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Stiebel Jr.
Address Bon Secours Hosp. Date signed 3/17/46

VS 150

937

G38425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G38425 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Abell Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MOLLIE MELISSA DYKES

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Larry Winfield Dykes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	6	hr. min.

9. Birthplace Maryland (Salisbury)
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter F. Dykes
13. Birthplace Md. (Salisbury)

MOTHER
14. Maiden Name Virginia Brown
15. Birthplace Md. (Salisbury)

16 (a) Informant Patient
(b) Address

17 (a) Burial (b) Date thereof 3/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parson's Cemetery
Location Salisbury, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 16 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1946 to 3/15 1946.
and that I last saw her alive on 3/15 1946
Immediate cause of death Respiratory failure — Duration 1 hr
Due to Cerebral hemorrhage — 1 hr
Due to Poliomyelitis, acute — ?
Other Conditions Partial paralysis of legs, upper extremities
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Vincent P.B. Fitzpatrick M.D.
Address Mercy Hosp Date signed 3/18/46

VS 150

G38426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

G38426 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Derby Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Derby Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA V. FELDMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife D. Albert Feldman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1874

8. AGE: Years	Months	Days	If less than one day
71	10	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lawrence Wolfe
13. Birthplace Penna.

MOTHER
14. Maiden Name - Ryan
15. Birthplace

16 (a) Informant Mr. D. Albert Feldman
(b) Address 2303 Derby Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46. (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 16 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 14, 1946 at 7.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1946 to MARCH 14 1946 and that I last saw him alive on March 14 1946

Immediate cause of death

	Duration
Cerebral Hemorrhage	3/11/46
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert D Bubert M. D.
Address 1805 Park Heights Ave Date signed 3/15/46

VS 150

G38427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 426

Registered No. G38427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 E. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles G. Bastian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mamie V. McCully
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1864

8. AGE: Years	Months	Days	If less than one day
80	3	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B & O Conductor

FATHER
12. Name Henry Bastian
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Edna Goss
(b) Address 809 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/ /46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Park
Location Washington Blvd.

18 (a) Funeral director John F. Henry Inc
(b) Address 1711 Light St

19 (a) (b) (Date received) (Registrar)

MAR 16 1946 Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th 1946, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1946 to March 16 1946 and that I last saw him alive on March 15 1946.

Immediate cause of death	Duration
Acute Dilatation of Heart	
Due to Pulmonary Tuberculosis	3 yrs
Due to Arteriosclerosis	2 yrs
Other Conditions Old Age	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Moon M. D.
Address 516 Cathedral St Date signed 3-16-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G38428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Route #2, HAMPSTEAD
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERTHA MABEL RODAMER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Solomon E. Rodamer
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1893

8. AGE: Years	Months	Days	If less than one day
52	5	3 4	hr. min.

9. Birthplace SOMERSET CO., LINCOLN TOWNSHIP, (Town, county, and state) PENNA.
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name DAVID HEMMINGER
13. Birthplace SOMERSET CO., PENNA

MOTHER
14. Maiden Name SUSANNA MOORE
15. Birthplace SOMERSET CO., PENNA

16 (a) Informant BERTHA M. RODAMER
(b) Address home (patient)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18/46 (month) (day) (year)
(c) Cemetery or crematory Black Rock
Location York Co. Pa.

18 (a) Funeral director Edw. C Tipton
(b) Address Hampstead Md.

(c) Date received MAR 16 1946 (Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 MAR. 1946, at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2nd Feb. 1946, to 19, and that I last saw her alive on 19.

Immediate cause of death Hypertensive arteriosclerotic Cardiovascular Renal Disease (Uremia) — Duration 4 years

Due to arteriolo nephrosclerosis + arteriosclerosis, general

Due to Diabetes mellitus

Other Conditions Bilateral mid thigh operative because of legs - dead

(Include pregnancy within 3 months of death)

Date of operation 1945 To Diabetic gangrene

Major findings of operation: 1 year.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Richard Compton M. D.
Address Hospital for Women Date signed 15 Mar 46

G38429

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 13 a

G38429 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Fallston
(If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alicia Spencer

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: B
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Davis
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Harford Co. Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Chambers
13. Birthplace Md

MOTHER
14. Maiden Name Susannah Williams
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 18 46 (month) (day) (year)
(c) Cemetery or crematory Tabernacle
Location Harford Co. Md

18 (a) Funeral director Chas E. Gross
(b) Address Benson Md.

19 (a) MAR 16 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1946, at 10 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1946, to 3-15 1946
and that I last saw h[illegible] alive on 3-15 1946

Immediate cause of death	Duration
a Pulmonary Congestion	
Pneumonia	7 days
Due to Chronic Glomerular Nephritis	
Due to	
Other Conditions Hypertension & Dis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene H. Conner M. D.
Address University Hosp. Date signed 3-15-46

G38130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G38130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 EASTERN AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 FLEET ST. E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM F. BAYTRO

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife STELLA BAUTRO
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 23 1870

8. AGE: Years	Months	Days	If less than one day
75	10 11	21 2/2	hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation REAL ESTATE
11. Industry or business FOR SELF

FATHER
12. Name UNKONWN
13. Birthplace POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant THADDEUS BAUTRO (SON)
(b) Address CHRISTOPHER AVE.

17 (a) BURIAL (b) Date thereof MAR. 18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Leilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 MAR 16 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 15 1946, at 9/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to March 17 1946 and that I last saw him alive on March 15 1946

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 3/15/46

Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR. — 3 YEARS

Due to DISEASE

Other Conditions INGUINAL HERNIA

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph F. Hyenga M.D.
Address 209 E. Chester St. Date signed 3/16/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G38431

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 St. Paul Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME: Daisy M. Weiskittel

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry C. Weiskittel

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 187[illegible]

8. AGE: Years 75 | Months 6 | Days 4 | If less than one day -- hr. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: -------

FATHER
12. Name: Calvin J. Grumbine
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Burcker
15. Birthplace: Maryland

16 (a) Informant: Harry C. Weiskittel, Jr.
(b) Address: 3022 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) MAR 16 1946 (Date rec'd by registrar) (b) Huntington for Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1946 to March 15 1946 and that I last saw h[illegible] alive on March 15 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 4 hours

Due to: arteriosclerosis — Duration: unknown

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury:

23. Signature: Francis W. Gluck M. D.
Address 715 Park Ave Date signed 3/16/46

VS 150

X

G38432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

G38432

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Gentzler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Beulah Gentzler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation Factory Worker

11. Industry or business

FATHER
12. Name Hengen Gentzler
13. Birthplace Pa.

MOTHER
14. Maiden Name Cara Law
15. Birthplace Pa

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar 16 1946 (month) (day) (year)

(c) Cemetery or crematory Stoverstown Union Cemetery
Location Stoverstown Pa.

18 (a) Funeral director C. O. Goodling
(b) Address Seven Valleys Pa.

MAR 16 1946 (Date rec'd by registrar) Registrar for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1946, to 3/16 1946, and that I last saw him alive on 3/16/ 1946.

Immediate cause of death	Duration
Cerebral anaemia and edema	
Due to Brain Tumor (Left Cerebral Lesion)	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation 3/16/46

Major findings of operation: Tumor

of autopsy: Brain Tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. M. Scott M.D.

Address University Hosp Date signed 3/16/46

G38433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 S. Charles St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth J. Walker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband ~~or wife~~ George Howard Walker
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 24, 1874

8. AGE: Years	Months	Days	If less than one day
71	11	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Thomas Oliver Kayler
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah Crowd
15. Birthplace Balto., Md.

16 (a) Informant George Howard Walker (Husband)
(b) Address 526 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Govans, Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) (b) Herrington Williams, M.D. (Date rec'd by registrar) (Registrar)

MAR 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15-46 19—, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1946 to 3-15 1946, and that I last saw her alive on 3-15 1946.

	Duration
Immediate cause of death: Hypostatic pneumonia	5 days
Due to: Hypertensive cardio-vascular disease	
Due to: Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Howard W. Chandler M.D.
Address S.B.C.H. Date signed 3-15-46

G38434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Webster St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) about 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Webster St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Mary (Marie) Ann Crispens

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Frederick Crispens
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Feb. 22, 1876
8. AGE: Years 70 | Months — | Days 22 | If less than one day ... hr. ... min.
9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name Kuhnrad Novak
13. Birthplace Bohemia

MOTHER
14. Maiden Name Catherine F. Brandt
15. Birthplace Bohemia

16 (a) Informant Bernard L. Crispens (Son)
(b) Address 1722 Webster St
17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Mar 18 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Balto Co., Md
18 (a) Funeral director A. Howard Evans
(b) Address 400 S. Charles St.
19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MAR 17 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946 at 10:07 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1946 to Mar. 14 1946 and that I last saw h[illegible] alive on Mar. 13 1946

Immediate cause of death	Duration
Hypertensive cardiovascular disease	2
Due to	
Due to	
Other Conditions Diabetes	2

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Lediel
Address 1326 Hanover St Date signed 3/14/46 (M.D.)

93D

G38435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G38435 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3221 Spaulding Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 18
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 Spaulding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Barditeh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Paul A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sholom
13. Birthplace Russia

MOTHER
14. Maiden Name Freida
15. Birthplace Russia

16 (a) Informant Paul A Barditeh
(b) Address 3221 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1427 E Balto St
(c) Date rec'd by registrar 3-17-1946 Huntingtn Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14-1946, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to 3-14 1946 and that I last saw her alive on 3-14 1946

Immediate cause of death	Duration
Chronic Cardiac Insufficiency	3 years.
Due to Cardiac Hypertrophy, Hypertension	15 years
Due to Auricular Fibrillation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Cooper
Address 2201 Fenton Place Date signed 3/15/46

VS 180

G38436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38436 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Hurley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TILLIE SOPHER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Isay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia
MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Isador Sopher
(b) Address 3309 Rochester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-46 (month) (day) (year)
(c) Cemetery or crematory Shaare Tefiloh
Location Windsor Mill Rd.

18 (a) Funeral director Paul Lewis Inc
(b) Address 1439 E. Balto St

19 (a) 3-16-1946 (Date rec'd by registrar) (b) Huntington Mills Baltimore, Md

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/46 19 13, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1936 to 3-15- 1946 and that I last saw h[e] alive on 3-15 1946

Immediate cause of death	Duration
chr. myocarditis	1936
arteriosclerotic heart	disease
Due to Hypertension	1936
chr. Nephritis	
Due to arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Mickelson M. D.
Address 2230 Eutaw Pl. Date signed 3/16/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G38437 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT Sts.
(c) Hospital or institution:
UNION MEMORIAL Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 KATHLAND AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John H MEYERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-8792

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	Widowed

6 (b) Name of husband or wife Ellen H. Meyers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1881

8. AGE: Years	Months	Days	If less than one day
64	10	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Superintendent Of Production

11. Industry or business Koppers Co.

FATHER
12. Name JACOB MEYERS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY WAGNER
15. Birthplace MARYLAND

16 (a) Informant Walter R. Meyers
(b) Address 3331 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto County Md.

18 (a) Funeral director George Weber & Son.
(b) Address 2503 Edmondson Ave.

19 (a) (b) Registrar

MAR 17 1946
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/46 19 , at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22/ 1946 to 3/15/ 1946, and that I last saw him alive on 3/15/46 19 .

Immediate cause of death PULMONARY EMBOLUS — Duration

Due to ARTERIO-SCLEROTIC CARDIO-VASCULAR Disease

Due to

Other Conditions CHRONIC HEART FAILURE.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul S. Cornell M. D.
Address U.M. Hospital Date signed 3-15-46

X

G38138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G38138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address "L" 5-Ambassador Apts. Canterbury Rd. and 39th St.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Canterbury Rd. & 39th St. Ambassador Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sedonia Winter

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Winter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1874

8. AGE: Years	Months	Days	If less than one day
71 ~~68~~	5	25	hr. min.

9. Birthplace New Windsor, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James T. Lambert
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Nicodemus
15. Birthplace Md.

16 (a) Informant Mrs. Ada Barclay
(b) Address 2539 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek Cem.
Location New Windsor, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Penna. Aves.

MAR 18 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1946 at 11 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 17 1946

G38439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38439
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Green Sts
(c) Hospital or institution:
Univ. Md. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson's Pk. Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 E. 5th.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie J. Mitchell

3 (b) If veteran, name war: N

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1893

8. AGE: Years 52 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Warsaw Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George C. Wright
13. Birthplace Warsaw Va.

MOTHER
14. Maiden Name Sadie Thompson
15. Birthplace Warsaw Va

16 (a) Informant George B. Mitchell
(b) Address 218 E. 5th. Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Wilson Lee
(b) Address 1217 E. Fayette St.

19 MAR 18 1946 Attending Physician Wm. Williams M.D.
Must be filed by (date)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946 at 5:07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 16 1946 to March 16 1946, and that I last saw h alive on Mar 16 1946.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H. Ade, Jr. M. D.
Address Univ. Hosp. Date signed 3/17/46

VS 150

C 638140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. C 638140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive, Balto Md
(c) Hospital or institution: US Naval Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 14 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Oxford St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Dunn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John Dunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1869

8. AGE: Years	Months	Days	If less than one day
77	1	9	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Kate
13. Birthplace France

MOTHER
14. Maiden Name Matilda Gilbert
15. Birthplace NY

16 (a) Informant Mary J. Dunn.
(b) Address 315 N. Oxford St. Arlington Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof MAR. 19-46 (month) (day) (year)
(c) Cemetery or crematory Arlington, Va.
Location Arlington. Va.

18 (a) Funeral director Harold Levinson
(b) Address 126 W. North Ave. Huntington Williams, Md

MAR 18 1946 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1946, at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1946 to 3/17 1946 and that I last saw her alive on 3/17 1946.

Immediate cause of death Acute cholecystitis with cholelithiasis — Duration 36 hrs

Due to

Due to

Other Conditions Healed myocardial infarction (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Above conditions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lt Waltzken
Address USN Hospt Balto Md Date signed 3/17/46
Balto Md Waltzken

G38441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

G38441 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 South Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/45

8. AGE: Years	Months	Days	If less than one day
	8	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Edward Smith
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Lillian Waters
15. Birthplace Baltimore Md.

16 (a) Informant Lillian Smith
(b) Address 22 S. Vincent St

17 (a) Burial (b) Date thereof 3/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location a.a. Co. Md.

18 (a) Funeral director Chas Allen & Son
(b) Address 727 N. Mount St
(Huntington Williams)
MAR 18 1946
(Date rec'd by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1946, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1946, to 3-15 1946 and that I last saw h/M alive on 3-15 1946.

Immediate cause of death Cardiac failure — Duration

Due to Pulmonary Stenosis Interventricular Septal defect — 8 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Wiesner M. D.
Address Univ. Hosp Date signed 3-15-46

G38142 G38142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1121 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SARAH BRESSNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Benly

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Hosp Record

(b) Address

17 (a) Burial (b) Date thereof 3-19-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Pikesville Md & Hamilton Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Baltimore St

19 (a) Huntington (Date rec'd by registrar) Registrar

MAR 18 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 16, 1946, at 9:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1946, to 3/16 1946, and that I last saw her alive on MARCH 16 1946

Immediate cause of death Cardiac decompensation

Due to rheumatic and arteriosclerotic Heart disease - Cardiac dilatation and hypertrophy - Aortic Stenosis and insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: See above

Duration
2 yrs.
? yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Bergin M. D.

Address Sinai Hosp. Balto, Md Date signed 3/17/46

G38443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38443 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs -
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Yorkaway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Kulinski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-46

8. AGE: Years	Months	Days	If less than one day
X	X	X	9 hr. 30 min.

9. Birthplace Balt - Md - (Town, county, and state)

10. Usual Occupation —

11. Industry or business Baby

FATHER
12. Name Paul Kulinski
13. Birthplace Miss

MOTHER
14. Maiden Name Christine Reid -
15. Birthplace Miss -

16 (a) Informant mother -
(b) Address 2509 York Way -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co Md

18 (a) Funeral director Lacy & Staley
(b) Address Fullton & Fayette

19 (a) Date received (b) Registrar Huntington Williams M.D.
MAR 18 1946
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1946 at 9:39 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Birth 19 to Death 19, and that I last saw h[illegible] alive on 3-16 1946

Immediate cause of death: Respiratory failure -

	Duration
Due to Prematurity (6 mos)	
Due to	
Other Conditions Possible atalectasis	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy: Yes?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Wm. A. Osborne M. D.
Address Mercy Hosp Date signed 3-17-46

X

G38444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G38444 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 N. Exeter (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Wed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-6-1960

8. AGE: Years 35 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace S.C. (City, county, and state)

10. Usual Occupation Ship worker

11. Industry or business

FATHER
12. Name John Green
13. Birthplace S.C.

MOTHER
14. Maiden Name Nellie Brown
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Joseph S. Lobl
(b) Address 1306 N. Central Ave

19 (a) (b)

MAR 19 1946 Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 11 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1946, to Mar 15 1946 and that I last saw him alive on Mar 15 1946.

Immediate cause of death: Lymphosarcoma of liver extensive — Duration: ?

Due to

Due to

Other Conditions Hx [illegible] — Duration: Recent

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Or other

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jon Williams M. D.

Address Johns Hopkins Hosp Date signed 3-15-46

G38445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G38445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 David Hill Ave
(c) Hospital or institution: Provident 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 David Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Olive [redacted] Batchelor White

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-2937

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	(Separated)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul. 3, 1906

8. AGE: Years	Months	Days	If less than one day
39	8	13	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Laundry Worker
11. Industry or business

FATHER
12. Name John Hall
13. Birthplace N.C.

MOTHER
14. Maiden Name Effie Mills
15. Birthplace N.C.

16 (a) Informant Johnny White (Son)
(b) Address 1309 David Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46 (month) (day) (year)
(c) Cemetery or crematory: [redacted]
Location Kinston-N.C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Rhmid Hill Ave.

19 (a) [redacted] (b) Huntington Williams, M.D.

MAR 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1946 at 6 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 P 3/16 1946 to 6 25 P 3/16 1946, and that I last saw h[illegible] alive on 3/16 1946.

Immediate cause of death	Duration
Coronal Thrombosis	
Due to Hypertensive - Cardio - Vascular Renal Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 709 Professional Bldg. Date signed 3/18/46

G38446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G38446 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Tudor Arms Apartments
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. University Pkwy at Wyman Pk
(If rural give location)
(e) If foreign born, how long in U. S. A.? NO years

3 (a) FULL NAME SUE WILSON SHRIVER

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ------

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1880

8. AGE: Years 65 | Months 5 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name William Shriver
13. Birthplace Union Mills, Md.

MOTHER
14. Maiden Name Roberta Lyon
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Jack Shriver
(b) Address Tudor Arms Apartments

17 (a) Burial (b) Date thereof 3/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director J. Evans Sons Inc
(b) Address 118 N. Pkt. Royal Ave

19 (a) ____ (b) ____
(Date received by registrar) (Registrar)

MAR 18 1946

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Mar. 15 1946, and that I last saw h[illegible] alive on Mar. 14 1946

Immediate cause of death	Duration
Hypostatic Pneumonia	3 days
Due to Carcinoma Pelvis	
following Carcinoma bladder	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. N. Hayward M. D.
Address 115 S Eager St Balto. Md. Date signed 3/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 G38 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett avenue
(c) Hospital or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --Baltimore
(c) City or town Towson---
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 W. Chesapeake ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? NO years

3 (a) FULL NAME LAURA JANE FIELDING

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife Daniel J. Fielding
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1859

8. AGE: Years	Months	Days	If less than one day
87	2	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Frederick J. Hinder
13. Birthplace Germany

MOTHER
14. Maiden Name Jane O'Rourke
15. Birthplace Ireland

16 (a) Informant Mrs. Edward J. Karl
(b) Address 211 W. Chesapeake ave. Towson

17 (a) Burial (b) Date thereof March 19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Marie
Location Towson

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address MAR 21 1946 Royal Ave

19 (a) (Date rec'd by registrar) (b) Harrington for Wilkinson Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946 to 3/15 1946, and that I last saw h[illegible] alive on 3/15 1946

Immediate cause of death	Duration
Myocardiac Cardio Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evans, Edw
M. D.
Address 503 Thorpe Bldg Date signed 3/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38148

BALTIMORE CITY HEALTH DEPARTMENT G38148
Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 E. 33rd street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 E. 33rd street
(If rural give location)
(e) If foreign born, how long in U. S. A.? NO years

3 (a) FULL NAME JACOB P. WILHELM

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna B. Wilhelm
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1869

8. AGE: Years	Months	Days	If less than one day
76	7	3	____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business

FATHER
12. Name John P. Wilhelm
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Anna B. Wilhelm
(b) Address 1625 E. 33rd street

17 (a) Burial (b) Date thereof 3/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Taylor Avenue

18 (a) Funeral director Chas. J. Graves Son Inc
(b) Address MAR 18 1946 Rosse Ave

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Mar 16 1946, and that I last saw h[illegible] alive on Mar 16 1946.

Immediate cause of death	Duration
Cardiac Dilatation	1 day
Due to Hypertensive Heart	7 yrs.
Due to Arterio-Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1500 E 33rd St Date signed 3/16/46 (M. D.)

VS 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G38149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret R. Elliott

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4 Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Rev. Beale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19 1881

8. AGE: Years 64 65 | Months 6 | Days 26 | If less than one day hr. - min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Booker Reece
13. Birthplace N. C.

MOTHER 14. Maiden Name Elizabeth Hood
15. Birthplace N. C.

16 (a) Informant Madaline Stroy
(b) Address 1628 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Thos. Geo. W. Hulbert
(b) Address 1631 Druid Hill Ave

19 (a) (Date received by local registrar) (b) Huntington, West Virginia

MAR 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1946 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1946 to 3-14 1946 and that I last saw her alive on 3-14 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Cardiac Vascular Renal	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Eichhorn M. D.
Address 805 W. Fremont Ave. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

D 38450 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie Green

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Shelby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1883

8. AGE: Years 63 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Benjamin Kelly
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Lydia Eagan
15. Birthplace

16 (a) Informant Mrs. Lena Frazier
(b) Address 1219 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Chas. Sylvester Hall
(b) Address 1625 Division St.

19 (a) MAR 18 1946 (Date rec'd by registrar) (b) Courtesy for Nellie A. Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1946 to 19 and that I last saw h alive on 19

Immediate cause of death Pulmonary Edema
Due to Chronic Myocarditis + Nephritis

Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Howell

Address Date signed 3/18/46

VS 150

G38151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B G38151 No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 549 N. Brooks
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 549 N. Brooks
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country G38150

3 (a) FULL NAME Charles H. Henry

3 (b) If veteran, name war
3 (c) Social Security Account No. None
4 Sex Male
5 Color or race Col.
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Helen
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 15 1882
8. AGE: Years 53 Months 2 Days 29 If less than one day hr. min.
9. Birthplace King & Queen Co. Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name William Henry
13. Birthplace Va
MOTHER 14. Maiden Name Unknown
15. Birthplace
16 (a) Informant Helen Henry
(b) Address 549 N. Brooks St.
17 (a) Burial (b) Date thereof 3-18-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Columbus Mem. Pk.
Location Baltimore Co. Md.
18 (a) Funeral director Wm. Ed. H. Sullivan
(b) Address 165 Druid Hill Ave
19 (a) MAR 18 1946 (b) Huntington for Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946, at 10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1946 to 3/17 1946 and that I last saw h.. alive on 3/14 1946

Immediate cause of death	Duration
Carcinomatosis	2 mos
Due to Carcinoma of Stomach	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Graham Higgins M. D.
Address 773 Madison Ave Date signed 3/19/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38452 — BALTIMORE CITY HEALTH DEPARTMENT — G38452

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs 2 mos 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Patapsco
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME: Harriet-Grace Eby.

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1873

8. AGE: Years	Months	Days	If less than one day
73	1	3	11 hr. 15 PM min.

9. Birthplace Baltimoreville Md.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER — 12. Name Samuel Eby
13. Birthplace Taneytown Md.

MOTHER — 14. Maiden Name Mary Elizabeth Six
15. Birthplace Taneytown Md.

16 (a) Informant E. Hartman
(b) Address Home for Incurables.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19 46 (month) (day) (year)
(c) Cemetery or crematory Wesley Un. & Chapel
Location Catonsville Md.

18 (a) Funeral director John C. Weishaar & Son
(b) Address 1911 Eastern Ave.

19 (a) MAR 18 1946 Registrar's signature Wilmington, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946, at 11 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1938 to March 17 1946 and that I last saw h[illegible] alive on March 16 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage and Right Hemiplegia	5 days
Due to Arteriosclerosis and Hypertensive Cardio Vascular Disease	20 years
Due to	
Other Conditions Chronic Cholecystitis	20 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St. Baltimore 2 Date signed 3/17/46

G38453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1920

G38453 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + CALVERT STs.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Taylor Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Raymond F. Willse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	MARRIED

6 (b) Name of husband or wife Rebecca Bowes Willse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 21 1883

8. AGE: Years	Months	Days	If less than one day
62	10	25	hr. min.

9. Birthplace N.Y. state (Town, county, and state)
10. Usual Occupation Surgeon
11. Industry or business

FATHER
12. Name Hudson G. Willse
13. Birthplace N.Y. state

MOTHER
14. Maiden Name Harriet Bowman
15. Birthplace N. Y. State

16 (a) Informant R. G. Willse
(b) Address 102 Hawthorne Rd C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 19 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto Co.

18 (a) Funeral director John O. Whitelock Co.
(b) Address 1900 Eutaw St Balto

19 (a) Date received (b) Huntington Williams, M.D.
MAR 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 16, 1946, at 8:58 PM

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 16, 1946, to MARCH 16, 1946, and that I last saw him alive on MARCH 16, 1946

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Coronary Thrombosis	
Due to	
Other Conditions Cardiac Hypertrophy with Aortic Regurgitation & Mitral Stenosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Cameron Montgomery Jr. M.D.
Address Union Memorial Hospital Date signed 3-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38454
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 m 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 St. Mocklenburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Green

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-3195

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Crewe, Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jack Green
13. Birthplace Va.

MOTHER
14. Maiden Name Mattie ?
15. Birthplace Va.

16 (a) Informant Asher Parham
(b) Address 172 N. Carolina St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)

(c) Cemetery or crematory
Location Crewe, Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1600 Bryantley Ave

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1946 at 11 P. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed March 14, 1946

X

G38455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38455 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE STS.
(c) Hospital or institution: Univ. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 53 Maryland Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA STRAUSS (Anna Strauss)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leon Strauss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1892

8. AGE: Years 53 | Months 2 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Fleet
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mr. Leon Strauss
(b) Address Annapolis Md.

17 (a) Burial (b) Date thereof 3.18.46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~cemetery~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Chas. Sondheim & Son
(b) Address 1902 Eutaw Place

19 (a) MAR 18 1946 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1946, at 5:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1946, to March 16 1946, and that I last saw her alive on 3/16 1941

Immediate cause of death Cerebral hemorrhage accident — Duration

Due to Hypertension CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Strauss M. D.
Address Univ. Hosp Date signed 3/16/46

VS 150

G38456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38456
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Monument & Rutland
(c) Hospital or institution: Sinai Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 week
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 20
6715 Park Heights Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green Acre Apts.
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph L. May

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Matilda M. May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1883

8. AGE: Years	Months	Days	If less than one day
62	6	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Trav.
11. Industry or business Salesman

FATHER
12. Name Louis May,
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Oppenheimer
15. Birthplace Germany

16 (a) Informant Miss. Edna May
(b) Address Temple Gardens Apts.

17 (a) Burial (b) Date thereof 3/ /46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sondheim & Son
(b) Address 1902 Eutaw Place

19 (d) MAR 18 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1946 at 10.44 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 9, 1946, to Mar. 16, 1946, and that I last saw him alive on March 16, 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary thrombosis	
Due to Arteriosclerotic heart disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Weisz
Address Sinai Hospital Date signed 3/16/46

G38457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

Registered No. G38457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3321 Richmond Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Luzerine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret V. Griggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1864

8. AGE: Years	Months	Days	If less than one day
81	8	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Cooper
13. Birthplace Baltimore

MOTHER
14. Maiden Name Eliza
15. Birthplace England

16 (a) Informant Mrs. William Healy
(b) Address 226 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) Date received by Local Reg. MAR 18 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15 1946 at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1946 to Mar 15 1946 and that I last saw h alive on Mar 14 1946

	Duration
Immediate cause of death Hemorrhage of rectum	1 hr
Due to Carcinoma of rectum	2 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L N Mayer D
Address 1522 E 32 Date signed 3/18/46 M.D.

VS 150

G38458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38458

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1439 W Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 W Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William P LeCompte

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Daisy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1875

8. AGE: Years	Months	Days	If less than one day
71		22	hr. min.

9. Birthplace Bree Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George LeCompte
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Naylor
15. Birthplace Md.

16 (a) Informant Daisy LeCompte
(b) Address 1439 W. Franklin St

17 (a) Burial (b) Date thereof 3 18 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. Co. Md.

18 (a) Funeral director Mrs. R. A. Elliott & Daughter
(b) Address 1129 N. Caroline St.

19 (a) [illegible] Huntington Williams M.D.
Date received by Local Registrar MAR 18 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1946 at 1 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1946 to 3/15 1946 and that I last saw h— alive on 3/-14 1946

Immediate cause of death Cardiac - Renal — Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Hatcher
Address [illegible] Date signed 3/18/46

X

G38459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G38459 Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1152 Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1152 Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Leila Jackson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	married

6 (b) Name of husband or wife James Wesley Jackson
(c) If alive, give age 8, years

7. Birth date of deceased (mo., day, yr.) 8-19-1884

8. AGE: Years	Months	Days	If less than one day
61	6	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own home

FATHER
12. Name David Alton
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Bias
15. Birthplace Maryland

16 (d) Informant Mrs Dinah Green
(b) Address 1152 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Leo. H. Kelly
(b) Address 1363 Presstman St

19 (a) (Date rec'd by registrar) MAR 18 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1946, at 4:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1946. to 3-17 1946.
and that I last saw her alive on 3-16 1946.

Immediate cause of death	Duration
Carcinoma of rectum	8 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank D. Saunders M. D.
Address 1029 N. Stricker St Date signed 3-17-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G38460 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Maryland G. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos. and 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Marlin W Short

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/1882

8. AGE: Years 63 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER 12. Name Frederick J. Short

13. Birthplace Md

MOTHER 14. Maiden Name Lettie Weant

15. Birthplace Md

16 (a) Informant F. J. Short

(b) Address Detour Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)

(c) Cemetery or crematory Hanglet

Location Ladiesburg, Md

18 (a) Funeral director C.O. Dressler

(b) Address Taneytown Md

19 (a) MAR 18 1946 Washington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9th 1946, to March 18th 1946, and that I last saw him alive on March 18th 1946

Immediate cause of death: Respiratory failure — Duration

Due to Left cerebral thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.E. Gonzalez

Address Maryland G. Hospital Date signed 3/18/46 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G38461 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 268 N. Hilton St.
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 268 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry F. Peddicord

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie E. (Keil)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1870

8. AGE: Years 75 | Months 8 | Days 15/16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and State)

10. Usual Occupation Retired Foreman

11. Industry or business Gas + Elec. Co.

FATHER 12. Name Peddicord

13. Birthplace Md

MOTHER 14. Maiden Name Unknown

15. Birthplace Md.

16 (a) Informant Mrs. Carrie E. Peddicord

(b) Address 268 N. Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location 3801 Frederick Road

18 (a) Funeral director Harry A. Wittle

(b) Address 4101 E. Lemmondon Ave

MAR 18 1946 (Date rec'd by Registrar) (b) Huntington Wittle, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/46, 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1946 to Mar 15 1946, and that I last saw him alive on Mar 13 1946

Immediate cause of death Cardiac Insufficiency — Duration

Due to Cancer of Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur C. Mornenger M.D.

Address 500 E North Ave Date signed 3/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

G38462 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT And SARATOGA STS.
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 HOMEWOOD AVE.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GEORGE HOWRY

3 (b) If veteran, name war: WORLD WAR I
3 (c) Social Security Account No.:

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MRS. MARY HOWRY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 2, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	13	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation BAKER
11. Industry or business WESTERN MD. DAIRY

FATHER
12. Name NATHAN HOWRY
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARY — "UNKNOWN"
15. Birthplace BALTIMORE, MD.

16 (a) Informant DECEASED
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Rita Winderfeld
(b) Address 914 Greenmount Ave
19 (a)

(Signature and title) Registrar
MAR 18 1946 Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 15 1946, at 6:08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1946, to 3/15 1946, and that I last saw h.im alive on 3/15 1946.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	2 days.
Due to Hypertension.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Hedrick
Address Mercy Hospital Date signed 3/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38463 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G38463 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 S. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 S. Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Julia Bulinske

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Kostanty

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1878

8. AGE: Years	Months	Days	If less than one day
66	-	19	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Kama
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Butha Stasiak
(b) Address 1024 S. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location Gunpowder Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) (b) Huntington Williams

MAR 18 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1946 at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1945 to 3/15 1946, and that I last saw h[illegible] alive on 3/14 1946.

Immediate cause of death	Duration
Bronchopneumonia	3 Days
Due to Arteriosclerotic C. V. D.	5 yrs.
Carcinoma Cervix	6 mos?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Karl Lemmon M.D.
Address 2125 N. Patterson Date signed 3/16/46

Ave X

MARGIN RESERVED FOR BINDING. — Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38464 4

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38464 Registered No.

CERTIFICATE OF DEATH 929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 GWYNN AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Gwynn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ERNEST J. EISENHUT

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0294

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ida A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1908

8. AGE: Years 37 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Cab Driver

11. Industry or business

FATHER 12. Name John Eisenhut

13. Birthplace Germany

MOTHER 14. Maiden Name Wilhelmina Voss

15. Birthplace Baltimore Md.

16 (a) Informant Ida A Eisenhut

(b) Address 318 Gwynn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)

(c) Cemetery or crematory Louden Park

Location Frederick Rd.

18 (a) Funeral director John J. Duda

(b) Address 2829 Hudson St.

19 (a) Date received MAR 18 1946 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1946, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 19, 1945, to MAR. 15, 1946, and that I last saw him alive on MAR. 14, 1946.

	Duration
Immediate cause of death: ACUTE EDEMA OF LUNGS	1 hour
Due to CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION (NON-RHEUMATIC)	3½ months
Due to HIGH BLOOD PRESSURE	10 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert E. Rudman M. D.

Address 2617 W. Baltimore St. Date signed Mar 15 1946

X

G38465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38465 ✓ 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 3700 N. Charles St
(c) Hospital or institution:
at Home (Northway Apts)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 N. Charles St
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME (PAUL CARLTON McNIEL) Paul McNeil

3 (b) If veteran, name war — No —

3 (c) Social Security Account No. — NONE —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Thelma M. McNiel

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) March 8 1883

8. AGE: Years 63 | Months 0 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Indiana
(Town, county, and state)

10. Usual Occupation Retired -

11. Industry or business —

FATHER
12. Name Dan'l T. McNiel
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah Pickett
15. Birthplace Raleigh N.C.

16 (a) Informant Charlotte E. McNIEL (daughter)
(b) Address 3507 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Stewart Mortuary
(b) Address 308 W. Mt. Ave

MAR 18 1946

19 (a) ____ (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1946, at 11:30 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions Arteriosclerotic C.V. Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury ____

23. Signature C. J. Leibrandt M.D.
Medical Examiner.
Date signed 3/16/46

G38466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38466 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 43 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: Baltimore
(c) City or town: Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Bird River Rd Box 50 R 14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) **FULL NAME**: William H Stumpf

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	216-10-4022	Male	White	Married

6 (b) Name of husband or wife: Frieda M Fischer
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 5 1899

8. AGE: Years	Months	Days	If less than one day
47	1	11	hr. min.

9. Birthplace: Carroll County Md (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business:

FATHER
12. Name: W Henry Stumpf
13. Birthplace: Carroll County Md

MOTHER
14. Maiden Name: Margaret Blum
15. Birthplace: Germany

16 (a) Informant: Mrs W H Stumpf
(b) Address: Bird River Rd Box 50 R 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mch 19 1946 (month) (day) (year)
(c) Cemetery or crematory: Zion Lutheran
Location: Stemmers Run Md

18 (a) Funeral director: Lazarus Funeral Home
(b) Address: 7401 Belair Road

19 (a) (b)
(Date received) (Registrar)

MAR 18 1946 Washington Millinery Md

NS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/16/ 1946, at 10.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/ 1946 to 3/16/ 1946, and that I last saw h[illegible] alive on 3/16 1946

Immediate cause of death: Intracerebral Hemorrhage — Duration: ?

Due to: Malignant Hypertension — Duration: 4 years

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: J. Hirschmann M. D.
Address: Sinai Hospital Date signed: 3/17/46

G38467 ✓ G38467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 135 N. Decker Ave.
(c) Hospital or institution:
6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaretha Wockenfuss

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Emil Wockenfuss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1-1871

8. AGE: Years 74 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Julius Schwartz
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Herpel
(b) Address 135 N. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director C. Howard Strong
(b) Address 3707 W. North Ave

MAR 12 1946 (Date rec'd by registrar) (b) Huntington Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1946, at 7.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to March 16 1946 and that I last saw him alive on March 16 1946

Immediate cause of death: ARTERIOSCLEROSIS — Duration: 5 Yrs

Due to:

Due to:

Other Conditions: CEREBRAL HEMORRHAGE — 8 DAY

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerry F. Kavanagh M.D.
Address 3328 W. Eldorado St. Date signed 3-14-46 M. D.

G38468

AB-99622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered G38468

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Clipper Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Webster Miles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Georganna (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10- 1875

8. AGE: Years	Months	Days	If less than one day
70	5	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Miles
13. Birthplace Md.

MOTHER
14. Maiden Name Young
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Chenault & Donovan
(b) Address 3615-17 Charles St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 18 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH March 15- 1946, at 11.50M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1- 1946, to 3-15 1946, and that I last saw him alive on 3-15 1946.

Immediate cause of death	Duration
Uremia	Unk.
Due to Degeneration Cardio Vascular Renal Disease, Arteriosclerosis, Chronic Nephritis, Bilateral	Unknown
Due to Benign Prostatic Hypertrophy	Unknown
Other Conditions Hypertension Cardio Vascular Renal Disease and Decompensation	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth E. Netterville M. D.
Address Bal. City Hosp. Date signed 3-16-46

X

G38469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1236 UNION AVE.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Union Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM W. ENSOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife SARAH ENSOR

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 9 1866

8. AGE: Years 79 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace MARYLAND.
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN.

16 (a) Informant EFFIE M. TRACEY
(b) Address 1236 UNION AVE

17 (a) Burial (b) Date thereof Mar 19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Wesley Chapel
Location Carroll Co/ Md

18 (a) Funeral director Chenoweth Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) MAR 18 1946
(Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MAR 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/46 19..., at 1:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis M.D.
Medical Examiner.
Date signed 3/16/46

G38470 BALTIMORE CITY HEALTH DEPARTMENT ✓ G38470
CERTIFICATE OF DEATH 937 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3682 Ash St.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 8
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3682 Ash St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Remy L. Prempert.
3 (b) If veteran, name war 1st WW.
(c) Social Security Account No. 213-20-1016
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Magie E. Prempert
6 (c) If alive, give age: 43 years
7. Birth date of deceased (mo., day, yr.) Feb 25 1901
8. AGE: Years 45 | Months - | Days 18 | If less than one day: hr. min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Ship Fitter
11. Industry or business Bethlehem Ship Yard.

FATHER
12. Name Arthur Prempert.
13. Birthplace North Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Magie E. Prempert.
(b) Address 3682 Ash St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/46 (month) (day) (year)
MAR 18 1946
(c) Cemetery or [illegible] St. Mary's
Location Hampden
18 (a) Funeral director Eberwein & Sonovan
(b) Address 3615-17 Eastern Ave.
19 (a) [illegible] Huntington Williams Md
MAR 18 1946
VS 150

MEDICAL CERTIFICATION
20. DATE OF DEATH March 15, 1946, at 10:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to March 15 1946, and that I last saw him alive on March 15 1946

	Duration
Immediate cause of death: Coronary Thrombosis	1 wk.
Due to: Hypertension CVD.	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. J. Schmaick MD
M. D.
Address 3714 Eastern Date signed 3-18-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G38471 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ST JOSEPHS HOSP
(c) Hospital or institution: BALTIMORE MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2434 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WM. P. BARRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	W	MARRIED

6 (b) Name of husband or wife JENNY
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 9/4/1911

8. AGE: Years	Months	Days	If less than one day
34	6	11	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation CRANE OPERATOR
11. Industry or business

FATHER
12. Name WILLIAM BARRY
13. Birthplace BALTO MD

MOTHER
14. Maiden Name VERONICA JURAS
15. Birthplace BALTIMORE, MD.

16 (a) Informant Mrs. Jean Barry
(b) Address 2434 E. Chase St.

17 (a) BURIAL (b) Date thereof 3/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL ROAD

18 (a) Funeral director M. J. Dubowski & Son
(b) Address 1808 Eastern Ave

19 (a) MAR 19 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1946 to 3-15 1946, and that I last saw him alive on 3-15 1946.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to BACTERIAL ENDOCARDITIS	
Due to RHEUMATIC H.D.	
Other Conditions ?	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: TRICUSPID IRLUULAR
of autopsy DISEASE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Wells M. D.
Address St Jos. Hosp. Date signed

VS 150

X

G38472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G38472 Registered No. 82a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 S. Durham Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 S. Durham Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANDRZEJ (HENRY) KMIOTEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Julia
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) November 10,1885

8. AGE: Years	Months	Days	If less than one day
57	4	5	..... hr. ..... min.

9. Birthplace Iasnie, Poland
(Town, county, and state)
10. Usual Occupation Retired - Chipper
11. Industry or business Bartlett Hayward

FATHER
12. Name Maciej Kmiotek
13. Birthplace Poland

MOTHER
14. Maiden Name Aniela Hacela
15. Birthplace Poland

16 (a) Informant Mrs. Julia Kmiotek
(b) Address 514 S. Durham Street

17 (a) Burial (b) Date thereof 3/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address MAR 18 1946 Eastern Ave.

19 (a) ..... (b) ..... Huntington Williams, M.E.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941 to March 15 1946 and that I last saw him alive on March 14 1946

Immediate cause of death	Duration
(1) Acute Cardiac Failure	2 days
Due to Cerebral Hemorrhage	4 days
Previous cerebral hemorrhage with left paraplegia	4 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D.
M. D.
Address 2413 E Monument St Signed X 3/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

638473 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeson & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3128 Northway Drive 14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L Bowerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harrison N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1870

8. AGE: Years 75 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: William Elliott
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Matilda Ailsworth
15. Birthplace: Virginia

16 (a) Informant: Family.
(b) Address: 3128 Northway Drive 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road 14

MAR 18 1946
(Date rec'd by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 1946, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1st 1946, to March 17 1946, and that I last saw h[illegible] alive on March 17 1946.

Immediate cause of death	Duration
Uremia	
Due to Acute Hypertensive Encephalitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Jonas Riley

Address Maryland Gen. Hospital signed 3/17/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

638474 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Home
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Donald A. Ledford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1944

8. AGE: Years 1 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur M. Ledford
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ruth Adams
15. Birthplace Maryland.

16 (a) Informant Mr Arthur Ledford
(b) Address Marriottsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-46 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem.
Location Sykesville, Md.

18 (a) Funeral director C. Harry Weis
(b) Address Sykesville, Md.

MAR 18 1946 (Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1946 at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1946 to 3-17 1946, and that I last saw h[illegible] alive on 3-17 1946.

	Duration
Immediate cause of death Shock + dehydration,	
Due to 1-2-3° infected burns	3 days
Due to	
Other Conditions Acidosis azotemia. (Include pregnancy within 3 months of death)	
Date of operation 0	
Major findings of operation: 0	
of autopsy: 0	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3-17-46 at 8 A.M.
(c) Where did injury occur? above ellers (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Scalded by hot water

23. Signature Osmund A. Wilcness M.D.
Address Univ. Hosp. Date signed 3-17-46

VS 150

For C. J. R. Davis, by Howard J. Mercein, M.D. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G38475 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 Round Hill Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Round Hill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ELLA J. ROBERTSON

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Benson Robertson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1860

8. AGE: Years 85 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name John A. Love
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Amy Brown
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Wm. H. Munroe
(b) Address 1304 Round Hill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received MAR 18 1946 (registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1945 to March 17 1946. and that I last saw h[illegible] alive on March 17 1946.

Immediate cause of death: Bronchopneumonia — Duration 2 days
Due to: age and disintegration of tissues
Due to:
Other Conditions: Blind and Deaf
Coloboma both eyes
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John A. Fletcher M. D.
Address 1 Draper Pl Date signed March 18 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G38476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 93D

G38476 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Hyndells 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Township Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Bell

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife George Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1895

8. AGE: Years 51 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace Irwin, Pa.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business Home

FATHER
12. Name Jerry Bevan
13. Birthplace Wales

MOTHER
14. Maiden Name Catherine Bevan
15. Birthplace Pa.

16 (a) Informant Hosp. Records.
(b) Address

17 (a) Burial (b) Date thereof 3/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 18 1946 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1946, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1946, to 3-17 1946, and that I last saw h.e.r. alive on 3-17-1946

Immediate cause of death Acute Pulmonary Edema — Duration 3d

Due to Cerebral Hemorrhage Accident — 5 d.

Due to Hypertension arteriosclerosis etc. — yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank N. Hartley M. D.

Address Church Home & Hosp. Date signed 3-17-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38477 G38477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst: (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia S. M. Frary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Harry Frary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1859

8. AGE: Years	Months	Days	If less than one day
86	10	11	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Myers
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Julia Stansbury
15. Birthplace Balto., Md.

16 (a) Informant Teeter Funeral Home
(b) Address - Greencastle, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed MAR 18 1946 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946 at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 17 1946 and that I last saw her alive on March 17 1946

Immediate cause of death: Apoplexy — Duration 10 hr.

Due to: Carcinoma

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. D. Richardson

Address 112 W. 35th Date signed Mar 17 1946

G38478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38478 Registered No. 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 E. Cross St.
(c) Hospital or institution:

24

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE S. FREITAG

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Freitag
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1858

8. AGE: Years	Months	Days	If less than one day
87	4	13	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam Denhard
13. Birthplace Germany

MOTHER
14. Maiden Name Lisetta Zimmer
15. Birthplace Germany

16 (a) Informant Mr. H. Homer Freitag
(b) Address 212 E. Cross St.

17 (a) Burial (b) Date thereof 3/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 18 1946 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1946, to March 17 1946 and that I last saw h[illegible] alive on March 17 1946

Immediate cause of death — Pulmonary Hypostasis — Duration 6 mo.

Due to — Hypostatic Pneumonia Terminal — 6 mo.

Due to — Arteriosclerosis — 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1279 Dillwyn St. Date signed 3/18/46

G38479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38479 / 830 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4512 Wakefield Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4512 Wakefield Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE E. FAHEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Edward J. Frhey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1876

8. AGE: Years	Months	Days	If less than one day
70	0	24	hr. min.

9. Birthplace Belgium
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Emil Cornell
13. Birthplace Belgium

MOTHER
14. Maiden Name Mary Wood
15. Birthplace Belgium

16 (a) Informant Mrs. George Herick
(b) Address 4512 Wakefield Rd.

17 (a) Burial (b) Date thereof 3/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address Baltimore, Md.

19 1946 (b) Huntington Williams Registrar
(Filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1946, at 8:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14 1946 to Mar. 16 1946, and that I last saw her alive on Mar. 15, 1946.

Immediate cause of death	Duration
Cerebral hemorrhage & paralysis	3 days
Due to Advanced arteriosclerosis ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Katie Dubbert
Address 2220 Garrison Blvd. Date signed 3/19/46

X

G38480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38480 / 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 W. Monument Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Baby Boy Holljes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: INFANT
6 (b) Name of husband or wife: -
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 13, 1946
8. AGE: Years | Months | Days 0 | If less than one day hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Henry W. Duvall Holljes
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Irene T. Cenette
15. Birthplace: Framingham, Mass.

16 (a) Informant: Mr. Henry W. D. Holljes
(b) Address: 225 W. Mondment Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 ([illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 17 1946 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1946 to 3-17 1946 and that I last saw h[illegible] alive on 3-17 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Fetal atelectasis	
Due to Prematurity	
Other Conditions Marked jaundice	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Univ Hosp Date signed 3-17-46

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38480 BALTIMORE CITY HEALTH DEPARTMENT G38480

CERTIFICATE OF DEATH 126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette St
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 W. Joppa Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Katie J. Naylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Augustus R. Naylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1882

8. AGE: Years 63 | Months 5 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Luther Sutton

13. Birthplace Maryland

MOTHER 14. Maiden Name Troyer

15. Birthplace Maryland

16 (a) Informant Mr. Augustus R. Taylor

(b) Address 119 W. Joppa Rd. Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Church

Location Black Road, Balto Co.

18 (a) Funeral director Howard A. Gill

(b) Address 19 W. Penna. Ave. Towson

19 (a) [illegible] (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15-1946, at 1 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1946 to 3-15 1946, and that I last saw h~~e~~r alive on 3-15 1946

Immediate cause of death Uremia — Duration 2 days

Due to Kidneys Ceased Functioning-Oliguria — 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-11-46

Major findings of operation: Cholecystitis & Cholelithiasis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.

Address Bon Secours Date signed 3-15-46

C38182

CWK-97890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered C38182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. This correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 13-
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Robert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steprett Dorsey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Helen Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19-1896

8. AGE: Years	Months	Days	If less than one day
49	3	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jule Dorsey
13. Birthplace ?

MOTHER
14. Maiden Name Nellie Brown
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School MAR 18 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 18 1946 (Date rec'd by registrar) (b) Hunter Jon Williams M.D.

MEDICAL CERTIFICATION R

20. DATE OF DEATH February 28 1946, at 12:10M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1945, to Feb. 28 1946, and that I last saw him alive on Feb. 28 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B Copeland Jr.
Address Balt. City Hosp. Date signed 3/8/46

VS 150

F 3370

G38483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38483 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument st. & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 N. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna Kramer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Jacob Kramer
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta -
15. Birthplace Russia

16 (a) Informant Albert J. Kramer
(b) Address 1607 N. Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Memory Gardens
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1739 E. Balto St

MAR 19 1946 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-46 19 , at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1931 to March 18 1946, and that I last saw him alive on 3/18/46 19

Immediate cause of death	Duration
Jaundice Icterus Severus	1/31
Chronic Myocarditis	1931
Due to Coronary Thrombosis	3/18/46
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Milton E. Solomon M.D.

23. Signature 129 S. Broadway M. D.
Address 3/18/46 Date signed

X

G38484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G38484

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1431 E. Fayette St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marion L. Carter (Marion Saunders)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Color or race: Female / Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-23

8. AGE: Years 23 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Phillip Carter

13. Birthplace Va.

MOTHER 14. Maiden Name Lillian Slaughter

15. Birthplace Va.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19-1946

(c) Cemetery or crematory Winston Virginia

Location

18 (a) Funeral director Billy Williams

(b) Address 1515 McElderry

19 (a) MAR 18 1946 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to Mar 15 1946 and that I last saw him alive on Mar 15 1946

Immediate cause of death: CEREBRAL EDEMA — Duration

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Nature of injury

23. Signature Freeman D. Stephens M. D.

Address Johns Hopkins Hosp. Date signed 3-15-46

VS 150

G38485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G38485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING. exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4810 Edmondson Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 90 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4810 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Mary Stoffel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Victor Stoffel
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1856

8. AGE: Years 90 | Months 1 | Days 2 | If less than one day -- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: ------

FATHER
12. Name: Francis Dreves
13. Birthplace: Bavaria

MOTHER
14. Maiden Name: Katherine Lafevre
15. Birthplace: Germany

16 (a) Informant: Mrs. Elmer W. Wilhide
(b) Address: 4810 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Meads and Son
(b) Address: 805 N. Calvert Street

MAR 18 1946 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1946, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946, to 3/18 1946, and that I last saw h[illegible] alive on 3/16 1946

Immediate cause of death	Duration
Acute Cardiac dilatation	3 hrs.
Due to Chronic myocarditis	
Due to Senility	
Arteriosclerosis	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation ----
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Polan
Address 47 N. Fulton Date signed 3/18/46 M. D.

X

G38486 and

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G38486 Registered No. 159

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline + Hoffmans
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 Urban Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hamlen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Edward Hamlen
13. Birthplace St. Albans, W.Va.

MOTHER
14. Maiden Name Lorraine Dietzler
15. Birthplace Glen Cloud, Penna.

16 (a) Informant Mrs. Hamlen
(b) Address 1235 Urban Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Henry W Meers & Son
(b) Address 805 N. Calvert St.

19 (a) (Date received by registrar) (b) Registrar

MAR 18 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946, to March 16 1946 and that I last saw him alive on March 16 1946.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Prematurity	
Due to Premature Labor	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Ayd Jr.
Address St. Joseph's Hosp. Date signed 3/16/46

X

C38487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. C38487

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynold & Dukeland
(c) Hospital or institution West Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County CARROLL
(c) City or town R. D. Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L Gunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: NANNIE E. GUNN deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1861

8. AGE: Years 84 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation FARMER (retired)

11. Industry or business

FATHER
12. Name William Gunn
13. Birthplace Maryland

MOTHER
14. Maiden Name Henrietta Spurrier
15. Birthplace Maryland

16. (a) Informant Mrs. Augustus Fleming
(b) Address Mt. Airy. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-46 (month) (day) (year)
(c) Cemetery or crematory Taylorsville
Location Taylorsville, Carroll Co. Md

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

MAR 19 1946 (Date rec'd by Registrar) (Huntington for) Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Jan 1946 to 17 March 1946 and that I last saw him alive on 17 Mar 1946.

Immediate cause of death: Respiratory Failure — Duration:
Due to: Cerebral Accident
Due to: Arteriosclerosis C.V. Dis. — over
Other Conditions: Pass. malignancy of Gall Bladder
(Include pregnancy within 3 months of death)
Date of operation 3/8/46
Major findings of operation: Pass. Malignancy of Gall Bladder
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo Ver G Dale
Address West Baltimore Gen Hosp Date signed 3/22/46 (M. D.)

VS 150

G38188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G38188

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Mem'l Hosp Eutaw & Lanvale Sts.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town P.O. Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** KATE BUCKINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James Buckingham

6 (c) If alive, give age dec'd years

7. Birth date of deceased (mo., day, yr.) June 5, 870

8. AGE: Years 75 | Months 9 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co Maryland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name James Criswell
13. Birthplace Maryland

MOTHER
14. Maiden Name Cordelia Conaway
15. Birthplace Maryland.

16 (a) Informant J Arthur Buckingham
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-46 (month) (day) (year)
(c) Cemetery or crematory Bethesda
Location Gist, Carroll Co. Maryland

18 (a) Funeral director E. M. Walls
(b) Address Westfield Md

MAR 19 1946 (Date filed) (b) Thos. Livingston Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** March 18 1946, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 2 1946, to Mch 18 1946. and that I last saw him alive on Mch 15 1946.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions Senile Debility
Fractured right femur
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-28-46 at M
(c) Where did injury occur? P.O. Sykesville, Carroll
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No.
(Specify type of place)
(e) Means of injury Fall from porch to pavement

23. Signature Howard J. Brown M.D.
Address Union Mem'l Hosp Date signed 3/19/46

Howard J. Brown. M. D.

G38489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No. G38489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 Hope St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ohlgart

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1864

8. AGE: Years	Months	Days	If less than one day
81	5	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Hunter Chief
11. Industry or business

FATHER
12. Name George O Ohlgart
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretha Engel
15. Birthplace Germany

16 (a) Informant Mrs. W. Bradburn
(b) Address 1713 Windemere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 E Gay St

19 (Date received) MAR 19 1946 Huntington for Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946, at 11:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1946 to March 17 1946 and that I last saw him alive on March 16 1946.

Immediate cause of death	Duration
BRONCHO PNEUMONIA.	2 days
Due to CEREBRAL HEMORRHAGE	7 MONTHS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Klemm M. D.
Address 3803 Edmondson Ave Date signed 3-18-46

VS 150

X

G38490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931 D

G38490 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 661 Bevan St.
(c) Hospital or institution Balto City Jail Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Known (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hunter Banks.

3 (b) If veteran, name war ? W
3 (c) Social Security Account No. ? W

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22. 1882

8. AGE: Years 63 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Balto md (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Samuel Banks Baltimore Md.
13. Birthplace Elizabeth Bull

MOTHER
14. Maiden Name Baltimore Md.
15. Birthplace

16 (a) Informant Thomas J. Mackin Md
(b) Address Balto City Jail

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

MAR 19 1946 Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/1946, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9/1946 to 3/16/1946 and that I last saw h[illegible] alive on 3/16/1946

Immediate cause of death: Myocardial Insufficiency — Duration 7 days
Due to: Myocarditis — ?
Due to: Arteriosclerosis — ?
Other Conditions: Convulsions Intoxication — 7 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Mackin
Address Balto City Jail Date signed 3/19/46

G38491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1194

G38491

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2705 Edison Highway
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Rogers Talbett

3 (b) If veteran, name war: W

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.) Oct 12th 1945

8. AGE: Years | Months: 5 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: Wilbert Talbott
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Florence Wood
15. Birthplace: Va.

16 (a) Informant: Wilbert Talbott
(b) Address: 2805 Edison Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory: Forreston
Location: Balto. Co. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 127 St. Paul St.

19 (a) MAR 19 1946 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1946 at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1946, to 3-18 1946 and that I last saw him alive on 3-18 1946.

	Duration
Immediate cause of death: Acute Cardiac failure	
Due to: Duofontile diarrhea	1 mo.
Due to:	
Other Conditions: Congenital anomalies of hands & feet	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Osmund Wisner M. D.
Address: Univ. Hosp. Date signed 3/22/46

G38192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. G38192

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cha Baltimore
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., ~~or days~~) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home & Hosp. (If rural give location)
(e) Citizen of foreign country? was born in (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie B. Nelson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 27th 1868

8. AGE: Years	Months	Days	If less than one day
77	5	20	hr. min.

9. Birthplace Richmond Va (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Nelson
13. Birthplace Va

MOTHER
14. Maiden Name Madge Grant
15. Birthplace Va

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul st.

MAR 19 1946 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17-1946 at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1945 to 3-17-1946 and that I last saw h[illegible] alive on 3-12-1946

Immediate cause of death	Duration
(a) Acute pulmonary Edema	6 d.
Due to (b) Hypostatic pneumonia	1 week.
Due to (c) Ca. of bowel?	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: old tbc. Simmonia-like Syndrome - Term. pneumonia
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Sheffey M. D.
Address Church Home & Hosp. Date signed 3-17-46

G38493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 W. Fayette st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Leasure

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Unk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: 46 Years | Months | Days | If less than one day hr. min.

9. Birthplace York Pa
(Town, county, and state)

10. Usual Occupation Organist

11. Industry or business

FATHER — 12. Name Unknown
13. Birthplace Unknown

MOTHER — 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Wife
(b) Address Unknown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 20-46 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (Date received by reg.) MAR 19 1946 (Signature of Registrar) Herrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1946, at 4:55 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Contusion of brain
Due to Intracranial Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/12/46 at 4 P. M. 4/2
(b) Where did injury occur Howard & Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ---
(d) Means of injury Probably fall

23. Signature Benedict Skibinski M.D.
Medical Examiner.
Date signed 3-13-46

VS 151

G38494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G38494

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4125 Norfolk Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4125 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Rabinowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Rabbi Rubin Selig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Laib Engel
13. Birthplace Poland

MOTHER
14. Maiden Name Miriam Wolman
15. Birthplace Poland

16 (a) Informant Mrs Sarah Goldberg
(b) Address 2808 Suffolk Ave

17 (a) Burial (b) Date thereof March 19, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 19 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946 at 10 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Mch 18 1946 and that I last saw h[er] alive on Mch 16 1946.

Immediate cause of death	Duration
Myocardial failure	
Due to arteriosclerosis	
Due to hypertension & senile degenerative changes	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman Seidel M. D.
Address 2404 Eutaw Pl Date signed 3/18/46

G38495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157B

Registered No. G38495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 No Curley St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? life years

3 (a) FULL NAME Baby Girl Crovo (Lois Pricilla Crovo)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9 1946

8. AGE: Years | Months | Days: 8 | If less than one day: — hr. — min.

9. Birthplace Baltimore Md

10. Usual Occupation

11. Industry or business —

FATHER
12. Name David Crovo
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary C. Jacob
15. Birthplace Baltimore Md.

16 (a) Informant Mary J. Crovo.
(b) Address 127 N. Curley Balt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Huntington Williamson (Date rec'd by registrar) Registrar

MAR 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 March 1946, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1946, to Mar 17 1946 and that I last saw her alive on Mar. 16 1946.

Immediate cause of death Intra spinal Infection. — Duration

Due to Spina Bifida & Meningocele

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address Date signed

G38496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G38496

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Fleetwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Fleetwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CAROLINA (LINA) ENGELHARDT

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Enlelhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1877

8. AGE: Years 69 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: ? Schoepf
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Hilda Engelhardt
(b) Address: 2903 Fleetwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-46 (month) (day) (year)
(c) Cemetery or crematory: First Evangelical Cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 19 1946 (b) Registrar

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH March 18 1946, at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1946 to Mar 18 1946 and that I last saw h[illegible] alive on Mar 18 1946

	Duration
Immediate cause of death: Bronchopneumonia (Hypostatic)	3 days
Due to: Carcinoma (Head of Pancreas)	3 yrs.
Due to:	
Other Conditions: Arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Harry S. Bagley
Residence: 1 W. Belvedere Date signed Mar 19/46

VS 150

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T 38497 06645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

628102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 2-days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Thomas Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7th 1887

8. AGE: Years	Months	Days	If less than one day
58	5	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Basil Brown (D
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Williams
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (ecords

17 (a) Burial. (b) Date thereof 3. 19. 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutis. Mem. Park.
Location Arbutis. Maryland.

18 (a) Funeral director William A Jackson.
(b) Address 916 Pennsylvania Ave.

19 (a) MAR 19 1946 Huntington Williams M.D.
(Signature and title of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1946 at 1.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13th 1945 to Mar 15 1946
and that I last saw him alive on Mar 15th 1946

Immediate cause of death: Cardiac Failure — Duration

Due to: Syphilitic Heart Disease

Due to: Aortic & insufficency + aortitis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: at alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Jervigan
Address Baltimore City Hosp. Date signed 3-16-46 M. P.

G38498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G38498 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 McEldery St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town) 2206 McEldery St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James C.Tudor Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie B.Tudor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.31-1894

8. AGE: Years 51 | Months 4 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Ice Man

11. Industry or business

FATHER
12. Name Wm. L.Tudor
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sophie Bauer
15. Birthplace Balto. Md.

16 (a) Informant Sophie B.Tudor
(b) Address 2206 McEldery St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.19-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd

18 (a) Funeral director John A. Miller
(b) Address 3834 Jefferson St.

(a) MAR 19 1946 (Date rec'd by Registrar) (b) [illegible] for Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940 to March 16 1946 and that I last saw him alive on March 15 1946

Immediate cause of death: Acute Cardiac Failure — Duration: 1 day

Due to: Carcinoma of Lung — Duration: 1 yr.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E Monument St Date signed 3/16/46

CWK-99940 G38499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38499 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 - 7 - 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 S. Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Zwick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry Zwick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12-1885

8. AGE: Years	Months	Days	If less than one day
60	7	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Ader
13. Birthplace Germany

MOTHER
14. Maiden Name Elvira Orf
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave. City

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 19 1946

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 17-1946 19 , at 2:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to March 17 1946, and that I last saw h alive on March 17 1946

Immediate cause of death	Duration
Coronary Occlusion	
Due to Diabetes mellitus	
Hypertension & arterio-	
Due to sclerosis	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Cardiac Hypertrophy Marked Coronary Sclerosis Arteriolar
of autopsy: sclerosis of Kidney

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert A. Farber M. D.
Address Balt. City Hosp. Date signed 3-18-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. 638500

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Quail St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Mooney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-46

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Balto Md
(Town, county and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Edward T. Mooney
13. Birthplace Ohio

MOTHER
14. Maiden Name Harriett Ingram
15. Birthplace

16 (a) Informant Edward Mooney
(b) Address Same as above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Balto Md.

18 (a) Funeral director H. G. Fadley
(b) Address Fulton & Fayette Sts

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1946 to 3-16 1946 and that I last saw ICP alive on 3-16 1946

Immediate cause of death	Duration
Cardio-Resp Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elias Shaker M.D.
Address Mercy Date signed 3-16-46

Huntington Williams Registrar

MAR 19 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1140

Registered No. 638501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Alameda
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Alameda Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Julia Dietrich

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1907

8. AGE: Years	Months	Days	If less than one day
38	9	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William T. Dietrich
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Biddison
15. Birthplace Balto. Co. Md.

16 (a) Informant Mr. Hammond Dietrich
(b) Address Ambassador Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) MAR 19 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to March 17 1946.
and that I last saw h[illegible] alive on March 16 1946.
Immediate cause of death
Lung Gangrene
Due to Ca. Bronchiectasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Sheldon Eastland M.D.
Address 1 E. Lexington St. Baltimore Md. Date signed 3/18/46

VS 130

G38502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G38502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Baker St - # 16
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Mary Harvey

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, (widowed) or divorced: Widow
6 (b) Name of husband or wife: John T. Harvey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec 11- 1880
8. AGE: Years: 65 Months: 3 Days: 6 If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Milenteer Cameron
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Annie Sockard
15. Birthplace: Maryland

16 (a) Informant: Mr. Emory Harvey
(b) Address: 3120 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory: Methodist Cem.
Location: Northeast, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) MAR 19 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12/46 19 at 7 02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 19 46, to 3/12/46 19.
and that I last saw h[illegible] alive on 3/12/46 19.

Immediate cause of death: Ca of Stomach — Duration: Unknown
Due to: Ca metastases to
Due to: liver —
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 2/12/46
Major findings of operation: Scirrhous Ca of Stomach
of autopsy: Ca metastases —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: E. D. Hedrick Jr
Address: Mercy Hospital Date signed 3/18/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G38503 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida County
(c) City or town Palm Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Golf View Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy Frances O'Hara

3 (b) If veteran, name war
(c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-39.

8. AGE: Years 7 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Francis Joseph O'Hara
13. Birthplace Mass.

MOTHER 14. Maiden Name Dorothy McCaldeff
15. Birthplace Mass.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/46 (month) (day) (year)
(c) Cemetery or crematory
Location West Palm Beach, Fla.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

MAR 19 1946 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1946 at 2.03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26-1946 to 3-18-1946 and that I last saw her alive on 3-18-1946.

Immediate cause of death: Cerebral Thrombosis — Duration

Due to: Hypertension Cerebral Artery

Due to:

Other Conditions: Congenital Heart Disease

(Include pregnancy within 3 months of death)

Date of operation 3-16-46

Major findings of operation: Pulmonary Stenosis

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. A. Cooley

Address The Johns Hopkins Hosp. Date signed 3-18-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

G38504 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 E. 33rd St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 E. 33rd St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry N. Schuncke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Curran
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) August 9, 1869

8. AGE: Years	Months	Days	If less than one day
76	7	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Broker - retired
11. Industry or business

FATHER
12. Name John Schuncke
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Sykes
15. Birthplace Germany

16 (a) Informant William H. Schuncke
(b) Address 627 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery ~~crematory~~ Greenmount
Location Greenmount & North Ayes.

18 (a) Funeral director John C. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

MAR 19 1946 (Date rec'd by Registrar) (c) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to March 17 1946, and that I last saw h[illegible] alive on March 17 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 6½ months

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Steinbach M. D.
Address 632 Gorsuch Ave. Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38505
CWK-97767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38505
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 9 days 3 9-
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Presser Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Leson Stewart

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Alberta Stewart (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1895

8. AGE: Years	Months	Days	If less than one day
50	9	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Stewart
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Thomas
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St

MAR 19 1946 (b) Huntington Williamsville, Md.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 18 1946; at 5:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1945, to March 18 1946, and that I last saw he alive on Mch 18 1946.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertensive + Arteriosclerotic Ht. Disease.	
Due to	
Other Conditions Benign Prostatic Hypertrophy. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert R. Faber
Address Balt. City Hosp. Date signed 3-19-46 M. D.

VS 150

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G38506

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Grove
(c) Hospital or institution:
University Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise Leach (Louise Leach)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles F. Leach
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 8/31/1891

8. AGE: Years	Months	Days	If less than one day
54	6	17	###### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Fink
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Schnitker
15. Birthplace Maryland

16 (a) Informant Charles F. Leach
(b) Address 1011 Aisquith Street

17 (a) Burial (b) Date thereof 3/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

MAR 19 1946 (b) [illegible]
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1946, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1946 to 3-18 1946, and that I last saw her alive on 3-18 1946.

Immediate cause of death	Duration
Congestive heart failure	
Due to Arteriosclerosis - cardiac - renal disease -	
Due to	
Other Conditions Uremia -	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Arteriosclerosis heart disease - chronic nephritis
of autopsy nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature George R. Callender M. D.
Address Edmondson & Grove Date signed 3-20-46

VS 150

G38507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

Registered No. G38507

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N Belnord Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry B. Kirkwood

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-12-9961

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Fritzges

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): November 14, 1874

8. AGE: Years	Months	Days	If less than one day
71	4	3	######## min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Night Watchman
11. Industry or business: Laundry

FATHER
12. Name: John J. Kirkwood
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary E. Broadwater
15. Birthplace: Maryland

16 (a) Informant: Mrs. Catherine Kirkwood
(b) Address: 921 N. Belnord Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/20/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: E. North Avenue

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) MAR 19 (Date rec'd by registrar) (b) 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1946, at 12:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gun shot wound of head

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: March 17, 1946 M.
(b) Where did injury occur? 921 Belnord Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Shot

23. Signature: Benedict Skinkle M.D. Medical Examiner.
Date signed: 3-18-46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G38508 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 E Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 E. Madison (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Andrews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Josie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1873

8. AGE: Years 73 | Months - | Days - | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Curry
13. Birthplace Va

MOTHER 14. Maiden Name Rebecca Delaze
15. Birthplace Va

16 (a) Informant Charles Curry
(b) Address 1462 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A. County

18 (a) Funeral director Mrs. Roberta A. Elliott Day
(b) Address 1129 W. Caroline St

19 (a) (Signature) (b) Registrar

MAR 19 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 4:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1946, to Mar 15 1946, and that I last saw h[illegible] alive on 3-13 1946

Immediate cause of death	Duration
Apoplexy (X)	1 wk
Due to Hypertension	
Due to Arterio-Sclerosis	
Other Conditions Mitral Insufficiency (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Lesher M.D.
Address 1612 E Monument Date signed 3/16/46

830a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

Registered No. G38509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Turner's Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 Pittsbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Married

6 (b) Name of husband or wife John Green
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1874

8. AGE: Years	Months	Days	If less than one day
49	.	13	hr. 1898 min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Geo Watson
13. Birthplace Va.

MOTHER
14. Maiden Name Mattal ?
15. Birthplace Va.

16 (a) Informant John Green
(b) Address 755 New Pittsburg Ave.

17 (a) Removal (b) Date thereof March 20 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Lynchburg Va.

18 (a) Funeral director Mrs Robert A Ellis & Son
(b) Address 1129 N. Carrolton St.

19 (a) MAR 19 1946 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946, at 7 20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Bronchial Asthma

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 18 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

G38510 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Durham st (If rural give location)
(e) Citizen of foreign country? Dr 9 (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Wilson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 6. 1871
8. AGE: Years 75 | Months - | Days 10 | If less than one day hr. min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Mary Maddox
15. Birthplace all

16 (a) Informant Elsie Miller
(b) Address 219 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bolton Ave.

MAR 19 1946 (Date rec'd by Registrar) (b) Huntington Wollschlaeger Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1946 at 8'18 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarczic M.D. Medical Examiner.
Date signed 3-16-46

X

G38511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1151

G38511 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 E. Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Devorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Emanuel Howard
13. Birthplace N.C.

MOTHER
14. Maiden Name Della ?
15. Birthplace N.C.

16 (a) Informant Irene Minor
(b) Address 1118 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bridgeport Ave Hunting Park Philadelphia, Pa.

19 (d) MAR 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 March 1946, at 10:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Feb 1946, to 15 March 1946, and that I last saw her alive on 15 March 1946

	Duration
Immediate cause of death: Septicemia	7 wk.
Due to: Peritonsillar Abscess	3 wks.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell M. D.
Address 121 Gimbrinth Date signed 3-14-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38512
CWK-68057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

Registered No. G38512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- 7- 10-
(e) Length of stay in Baltimore (yrs., mos., or days) 64- 9- 0-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Johansen
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Johenson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1881

8. AGE: Years	Months	Days	If less than one day
64	9	0	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joshua Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Clark
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Isaiah L. Brown
(b) Address 1054 W Monty or my St

19 (a) (b)
(Signature of local registrar) Registered
MAR 19 1946 Huntington Williams
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17-1946 19 , at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1941 to March 17 19 46 and that I last saw h im alive on March 17 1946

Immediate cause of death	Duration
Bronchopneumonia	
& Pulmonary edema	
Due to Carcinoma of Stomach	
& metastasis to testis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 3-18-46

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G38513 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 WASH. BLVD
(c) Hospital or institution: DOCTOR'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 1 DAY

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 BALTO ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL ROPER

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1946

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 30 min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE.
11. Industry or business

FATHER
12. Name JOHN HOWARD ROPER
13. Birthplace FLORIDA

MOTHER
14. Maiden Name CLAUDINE ALMA BUSH
15. Birthplace ROANOKE VA

16 (a) Informant CLAUDINE ALMA ROPER
(b) Address 1822 BALTO. ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20-1946 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 710 Frederick Ave

19 (a) [illegible] (b) [illegible] Registrar

MAR 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 17 1946, to Mar 17 1946 and that I last saw her alive on Mar 17 1946

Immediate cause of death: Respiratory failure — Duration

Due to: Premature birth (24 weeks)

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Shorofsky M.D.

Address 601 N. Monroe St. Date signed 3/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G38514 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Brunswick St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 505 Brunswick St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Roeder

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frederick H. Roeder
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) February 5, 1848

8. AGE: Years 98 | Months 1 | Days 13 | If less than one day: hr. ____ min. ____

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Charles F. Roeder
(b) Address: 505 Brunswick Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Maryland

18 (a) Funeral director: George L. Schubert
(b) Address: 2101 Frederick Rd.

19 (a) Filed by Registrar MAR 19 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 18 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1946, to Mar 17 1946, and that I last saw h.. alive on Mar 17 19 46.

Immediate cause of death	Duration
Cerebral Hemorrhage	8 days
Due to	
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry Glassman M. D.
Address 7687 Westlawn Ave Date signed Mar 19, 46

X

G38515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

G38515 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Parris
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 48 47 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)

10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Robert Witler
13. Birthplace Md

MOTHER
14. Maiden Name Ella Shipley
15. Birthplace Md.

16 (a) Informant Mr. W. H. Hutchins
(b) Address Owings, Calvert Co.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Ave

18 (a) Funeral director W. H. Hutchins's
(b) Address Owings, Md

19 (a) MAR 19 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1946, at 1115 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1946 to 3/18 1946, and that I last saw h.. alive on 3/18 1946.

Immediate cause of death	Duration
Cardiac Resp failure	
Due to Metastatical	
Lymphosarcoma	
Due to	
Other Conditions Lobar pneumonia Heart left	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Reuss Jr. M. D.
Address St Agnes Hosp Date signed 3/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY

G38516

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 131a

G38516

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Baltimore
City or town Masonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
3324 Hollins St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Masonville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3324 Hollins St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Holy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph Holy

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) April 9, 1883

8. AGE: Years	Months	Days	If less than one day
62	10	24	hrs. min.

9. Birthplace Bohemia
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mr Joseph Holy Jr
Address 4212 Curtis Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/46 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glenburnie on Annapolis Blvd.

18. Funeral director John F. Denny Inc. Carl Hess
715 Light St Huntington Williams, M.D.

19. 3/4 1946 (Date rec'd by Registrar) 3/6 1946 H. W. Hebeid Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946 at 5:30p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1946 to Mar. 3 1946 and that I last saw h. er alive on 1946

Immediate cause of death Cardiac failure, pulmonary edema

Due to Hypertension Cardiovascular renal disease

Due to

Other conditions Insanity (depression) psychosis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M. D.
Address 203 Calafee Ave Date signed 3/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38517
CWK-82784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /33B

G38517
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-7-26 27
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4256 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise D. Davis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1879

8. AGE: Years	Months	Days	If less than one day
66	8	19	hr. min.

9. Birthplace Florida
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Davis
13. Birthplace North Carolina

MOTHER
14. Maiden Name ALEXINA Eva Horsey
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Hampden
Location Baltimore, Maryland
18 (a) Funeral director Dugan Funeral Home
(b) Address 3631 Falls Road
19 (a) (Date received by registrar) MAR 19 1946 Registrar Huntington Williams, M.D.

V-1150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1943 to March 18 1946, and that I last saw h alive on March 18 1946

Immediate cause of death	Duration
Uremia	
Due to Hydronephrosis rt. Kidney	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigon M. D.
Address Baltimore City Hosp Date signed 3-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38518

BALTIMORE CITY HEALTH DEPARTMENT

Dr. Blake

CERTIFICATE OF DEATH 13B

Registered No. G38518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Harford Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claudie H. Peterkin

3 (b) If veteran, name war	3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1920

8. AGE: Years	Months	Days	If less than one day
25	4	6	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Herman Peterkin
13. Birthplace South Carolina

MOTHER
14. Maiden Name Shadie Peterkin
15. Birthplace South Carolina

16 (a) Informant Shadie Manning
(b) Address 1208 Harford Ave

17 (a) Burial (b) Date thereof 3/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Layne Sandys
(b) Address 1412 E. Preston Street

19 (a) (b) Huntington Williamsport

MAR 19 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1946, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1946 to 3/16 1946
and that I last saw h[illegible] alive on 3-16 1946

Immediate cause of death
Due to Bronchial Pneumonia and Pleurisy — Duration 8 wks
Due to Bronchitis
Due to Exposure
Other Conditions (over)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Blake M. D.
Address 1357 N. Central Ave. Date signed 3-19-46

G38519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38519 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 Hollins st.
(c) Hospital or institution: ~ 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Hollins st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country ~

3 (a) FULL NAME Peter Paulauskas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Frances E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1880

8. AGE: Years	Months	Days	If less than one day
65	8	18	hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Anthony Paplauskas

13. Birthplace Lithuania

MOTHER 14. Maiden Name Victoria Lenauskas

15. Birthplace Lithuania

16 (a) Informant Mrs Frances E Paulauskas

(b) Address 815 Hollins St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem

Location Pikesville, Md

18 (a) Funeral director John T Gowan & Son

(b) Address 901-03 W Hollins St.

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 19 1946 Burlington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1946, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp + Exp. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Catarelli M.D.
Medical Examiner.

Date signed 3-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38520 — CWK-99947

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

931

G38520 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs. 5 mos. 8 ds.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 N. Luzerne Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Curtain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9-1872

8. AGE: Years	Months	Days	If less than one day
73	5	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Charles C. Lewis (D)
13. Birthplace Wahington, D.C.

MOTHER
14. Maiden Name Catherine Battersby (D)
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md.

18 (a) Funeral director John C. Miller Inc.
(b) Address 243 E. Oliver St.

19 (a) MAR 19 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17-1946 19 , at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to March 17 1946 and that I last saw h. er alive on March 17 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernegan M. D.
Address Baltimore City Hosp. Date signed 3-17-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 70

G38521 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1945

8. AGE: Years | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jonney Jackson
13. Birthplace Virginia

MOTHER 14. Maiden Name Sylvannah Johnson
15. Birthplace S. C.

16 (a) Informant Sylvannah Johnson
(b) Address 1913 E. Eagel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1100 Bentley ave

19 (a) Date received MAR 19 1946 (b) Registrar Washington Williams, Mar. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 8:30 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Staten Thymics — lymphaticus

Due to

Other Conditions Rickets

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed March 18 1946

64

Dr. Sawyer G38523 ✓ G38522
4808 Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The spelling of names is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5215 Catalpha Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Catalpha Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mc Crorie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife John Mc Crorie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1879

8. AGE: Years	Months	Days	If less than one day
66yrs.	6	22	hr. min.

9. Birthplace Scotland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Robert Yule
13. Birthplace Scotland

MOTHER
14. Maiden Name M.S.Mc Leod
15. Birthplace Scotland

16 (a) Informant Mrs. John Mc Crorie
(b) Address 5215 Catalpha Road

17 (a) Burial (b) Date thereof 3/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

MAR 19 1946 (b) Huntington Williams M.D. Registrar
Date rec'd by Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1946, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Mar. 18 1946 and that I last saw HER alive on Mar. 17 1946

Immediate cause of death: Edema. Carcinoma of Gall-bladder — Duration: 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Aug. 1, 45
Major findings of operation: Edema. Carcinoma of Gall bladder
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer
Address 4808 Harford Rd. Date signed 3/18/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G38523 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Min
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 W. 31st Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Krieg

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1946

8. AGE: Years | Months | Days | If less than one day: 0 hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Kenneth Edward Krieg
13. Birthplace

MOTHER
14. Maiden Name Mary Carolyn ~~Debenedetto~~ Wolf
15. Birthplace Baltimore Md.

16 (a) Informant Union Memorial Hosp.
(b) Address 33rd & Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21-46 (month) (day) (year)
(c) Cemetery or crematory St. Paul Luth. Cem.
Location Perryman, Md.

18 (a) Funeral director John Jarvis
(b) Address Aberdeen, Md.

19 (a) (b) Registrar
MAR 19 1946
VS 150
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1946, at 3:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Mar 1946 to ... 19..., and that I last saw h... alive on ... 19...

Immediate cause of death: Neo-natal death due to Cardiac Failure. — Duration
Due to: Congenital Malformation of Heart
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Anasarca, Congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? — — —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature John G. Thurman Jr. M.D.
Address 9 E. Chase St. Date signed Mar 18-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G38524
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town Hickman
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Catlett St.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas, James Claudy

3 (b) If veteran, name war

3 (c) Social Security Account No. 414-34-1573

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Jessie May Inman
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1894

8. AGE: Years	Months	Days	If less than one day
52	0	16	hr. min.

9. Birthplace Carlisle Co. Ky.
(Town, county, and state)
10. Usual Occupation Diesel operator
11. Industry or business U.S. Engineer Corps

FATHER
12. Name William Thomas
13. Birthplace Ky.

MOTHER
14. Maiden Name Sephronia Elizabeth Dublin
15. Birthplace Ky.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23 46 (month) (day) (year)
(c) Cemetery or crematory Hickman
Location Fulton-Hickman Kentucky

18 (a) Funeral director Dew Funeral Home Inc.
(b) 64 Hamburg Road, Catonsville, Md.

19 (a) MAR 19 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18 1946 at 8:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1946 to Mar. 18 1946 and that I last saw him alive on Mar. 18 1946.

Immediate cause of death Lymphosarcoma — Duration UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Robert S. Mc Clintock
Robert S. Mc Clintock, PH Surgeon M. D.
Address US Marine Hospital Balto, Md. Date signed 3/19/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38525 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Dallas st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Dallas st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-9050

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary A. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th 1906

8. AGE: Years	Months	Days	If less than one day
39	9	28	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Crown Central Pet Co.

FATHER
12. Name Fleet Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Lottie Ambrose
15. Birthplace Md

16 (a) Informant Mary A. Smith
(b) Address 1804 Dallas st.

17 (a) Burial (b) Date thereof 3/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) Filed MAR 20 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 18th 1946, at 11 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1945 to 3/18 1946, and that I last saw h. alive on 3/18 1946.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph V. Blum M. D.
Address 706 E. Preston
Date signed 3/19/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G38526

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 482 Windsor Mill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 482 Windsor Mill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Helmich

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife J. Gustav

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1859

8. AGE: Years 86 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ernst Michelmann
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Schroeder
15. Birthplace Germany

16 (a) Informant Clara A. Piper
(b) Address 482 Windsor Mill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son Inc
(b) Address 1217 Park Ave

19 (a) MAR 20 1946 (Date rec'd by registrar) Huntington Mills, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 March 1946 at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion
Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Stephens M.D. Medical Examiner
Date signed 18 March 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939

G38526 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Aisquith Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE EDELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 75 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Wm J Wildroot

(b) Address 1105 Virginia St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/46 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Baltimore Md

18 (a) Funeral director Wilson Lord Dix

(b) Address 2424 Maryland Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 21 1946

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/46 19..... at 5:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner

Date signed 3/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G38528 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6411 Rosemont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6411 Rosemont Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine K Linne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George A Linne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11 1867

8. AGE: Years	Months	Days	If less than one day
78	5	7	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Stephen Soter
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Keen
15. Birthplace Germany

16 (a) Informant Mrs Gustav Otter
(b) Address 6411 Rosemont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 22 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Lasch Funeral Home
(b) Address 7401 Belair Road

19 (a) (Registered by registrar) (b) Registrar

MAR 20 1946
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 18/46 19 at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 19 46 to Mch 18 19 46 and that I last saw [illegible] alive on Mch 17 19 46

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Pneumonia

Due to

Other Conditions Arteriosclerosis Heart and cerebral

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Hannon M. D.
Address 1401 St Paul St Date signed 3-19-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

638529 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Sawyer Oak Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Mindel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Samuel Mindel
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Nov 10, 1897

8. AGE: Years	Months	Days	If less than one day
48	4	9	hr. min.

9. Birthplace [redacted] Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jakel Schwartzman
13. Birthplace Russia

MOTHER
14. Maiden Name Eta Balin
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof 20 Mar 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 20 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 March 1946, at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 March 1946, to 19 March 1946, and that I last saw her alive on 19 March 1946.

	Duration
Immediate cause of death [redacted]	
Due to [redacted]	
Due to Chronic severe rheumatic heart disease	Approx 30 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Richard Compton M. D.
Address Hospital for Women Date signed 19 March 46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38530 | BALTIMORE CITY HEALTH DEPARTMENT | 937 | G38530

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 545 W. Lanvale St
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIA BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant Mrs. Ella Nelson
(b) Address 545 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Riddle St.

(a) Date rec'd by registrar MAR 20 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 14 1946, to Mar 17 1946, and that I last saw h.e.r. alive on Mar. 17 1946.

Immediate cause of death	Duration
Myocardial degeneration	
Due to Cerebro Vascular disease	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Hamblin Phillips M. D.
Address 1543 Penna. Ave Date signed 3/19/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38531

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38531 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Wilson Street
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Wilson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALEXANDER HASKINS

3 (b) If veteran, name war
3 (c) Social Security Account No. 217-01-7858

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Evelyn Haskins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 17, 1881

8. AGE: Years	Months	Days	If less than one day
64	6	1	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Alexander Haskins
13. Birthplace Va.

MOTHER
14. Maiden Name Lillian Hall
15. Birthplace Va.

16 (a) Informant Mrs. Evelyn Haskins
(b) Address 403 Wilson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
Address 578 W. Riddle St.

19 MAR 20 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 18, 1946 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1945 to Mch 18 1946 and that I last saw h[illegible] alive on Mch 18 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 mos, 4 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. Garland Hemsley, M.D.
Address 1534 Druid Hill Ave Date signed Mch 19, 1946

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G38532 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 E 25th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) **FULL NAME** Jean Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John M Walker Jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr - 8 - 1918

8. AGE: Years 27 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Arkansas (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Robert Malone
13. Birthplace Arkansas

MOTHER
14. Maiden Name Evelyn Crain
15. Birthplace Arkansas

16 (a) Informant John M Walker Jr.
(b) Address 331 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 20th 1946 (month) (day) (year)
(c) Cemetery or crematory St Thomas'
Location Baltimore Forest Rd

18 (a) Funeral director Henry W Jenkins Sons Co
(b) Address McCulloh & Richard Sts

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946, at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar - 9 - 1946 to Mar - 18 - 1946, and that I last saw her alive on Mar 18 1946.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Lung Metastasis	
Due to Carcinoma of Breast	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George F Schwing M.D.
Address Union Memorial Hosp Signed 3/18/46

MAR 20 1946 Registration Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94B

REGISTRAR'S NO. G38533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Temple Garden Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** THERESA SCHOOLHAUS.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3rd. 1863.

8. AGE: Years	Months	Days	If less than one day
82	7	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Schoolhaus,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sophie Brown,
15. Birthplace Germany.

16 (a) Informant Mr. Jerome W. Kahn (Nephew)
(b) Address Temple Garden Apts.

17 (a) Burial (b) Date thereof 3.20.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 (a) MAR 20 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th. 1946 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1946 to 3/18 1946 and that I last saw h[illegible] alive on 3/18 1946.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Cardiac failure	
Due to Arteriosclerosis & Senile Psychosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frederick Lantz M.D.
Address Temple Garden Apts. Date signed 3/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38534 BALTIMORE CITY HEALTH DEPARTMENT G38534
CERTIFICATE OF DEATH 50 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 Raspe ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose C. Vanik

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Chas Vanik
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) July 4 1904

8. AGE: Years 41 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name George Boerner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Schreiber
15. Birthplace Baltimore

16 (a) Informant Charles Vanek
(b) Address 129 Raspe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20th (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Curtis

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Callow

19 (a) MAR 20 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1946, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1946 to 3-16 1946 and that I last saw h[illegible] alive on 3-16 1946.

Immediate cause of death	Duration
Spontaneous subarachnoid	
Due to hemorrhage	
Due to	
Other Conditions Carcinoma - Breast & Metastasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St. Josephs Hosp. Date signed 3-16-46

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

(Registered No.) G385[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4709 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Caroline (Carrie) Grauer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry Grauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 4- 1862

8. AGE: Years 83 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name John Weibrecht
13. Birthplace Germany

MOTHER
14. Maiden Name Don't know
15. Birthplace Germany

16 (a) Informant Henry Grauf
(b) Address 3900 Erdman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2007 Orleans St

19 (a) (Date rec'd by registrar) MAR 20 1946 (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th 1946, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1939 to 3/19 1946.
and that I last saw her alive on 3/18 1946.

Immediate cause of death Ch. Myocarditis — Duration 7 years

Due to Hypertension Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature JS Harding MD

Address 4810 Belair Rd Date signed 3/19/46

Huntington Williams, MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

638536 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 Ellamont St.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora M. Bond

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Alexander B. Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1866

8. AGE: Years	Months	Days	If less than one day
79	6	10	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James H. McKee
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name ?. Sinclair
15. Birthplace Ohio

16 (a) Informant Mrs. Helen B. Herold
(b) Address 2528 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22, 1946 to Mar. 18 1946 and that I last saw her alive on Mar. 18 1946.

Immediate cause of death	Duration
Cerebral hemorrhage & paralysis	25 days
Due to Advanced Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Stella S. Tickner
Address 3220 Garrison Blvd. Date signed 3/20/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38537 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 562 S. Chapel Gate Lane
(c) Hospital or institution:
Ventnor Nursing Home 27 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4663 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. McCUBBIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Barbara E. McCubbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1869

8. AGE: Years	Months	Days	If less than one day
76	5	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Builder & Contractor
11. Industry or business Self

FATHER
12. Name Unknown McCubbin
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Edith M. Hudson
(b) Address 4702 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18, 1946, at 8:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to 3/18 1946, and that I last saw h[illegible] alive on 3/18 1946

Immediate cause of death: Repeated Myocardial Infarct — Duration: 6 days
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3316 Fredrick Ave Date signed 3/18/46

VS 150

MAR 20 1946

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38538 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Avon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Avon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Fields (HAMILTON - Middle Name)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Margaret Agnes Fields

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1876

8. AGE: Years 69 | Months 3 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Batterton Md.
(Town, county, and state)

10. Usual Occupation Asst. Supt. Retired

11. Industry or business American Sugar Ref. Co.

FATHER
12. Name Wm. Fields
13. Birthplace Md.

MOTHER
14. Maiden Name ? Lloyd
15. Birthplace Md.

16 (a) Informant Mr. Wm. J. Fields
(b) Address Kline Woods Ithaca N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves.

19 (a) MAR 29 1946 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1946, to March 18 1946, and that I last saw him alive on March 17 1946.

	Duration
Immediate cause of death: Cerebral hemorrhage	4 days
Due to: Hypertension	15 years
Due to: Arteriosclerosis	15 years
Other Conditions: Vascular nephritis	15 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur Lankford Jr. M. D.
Address 115 E. Eager St Date signed 3-18-46

VS 150

Huntington Williams, M.D.

LE 3394

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38533 Registered No. 12213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 S. Light St.
(c) Hospital or institution: Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 555 Eastern Ave. North Pt. Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hector Brown HECTOR H. BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1887

8. AGE: Years	Months	Days	If less than one day
58	4	5	hr. min.

9. Birthplace Portland (Town, county, and state)
10. Usual Occupation Deisel Salesman
11. Industry or business Self

FATHER
12. Name Victor Brown
13. Birthplace Portland

MOTHER
14. Maiden Name Annie Scherer
15. Birthplace Portland

16 (a) Informant Annie S. Brown
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery Oaklawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pay Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1946, at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1946 to 3-15 1946 and that I last saw h. alive on 3-15 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 8 days
Due to unknown cause
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hamburg M.D.
Address S.B.G.H. Date signed 3/19/46

MAR 20 1946 Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 43a G38540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: McKenna Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7205 Oxford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES SHRIVER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Sara Newell Chase Shriver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29, 1865

8. AGE: Years	Months	Days	If less than one day
80	4	19 20	hr. min.

9. Birthplace Hightstown, N. J.
(Town, county, and state)
10. Usual Occupation Investment Counsellor(rt'd)
11. Industry or business Alexander Brown & Sons

FATHER
12. Name Samuel Smith Shriver
13. Birthplace Union Mills, Carroll Co., Md.

MOTHER
14. Maiden Name Caroline H. McCluskey
15. Birthplace Pa.

16 (a) Informant Mrs. Gustav Klemm
(b) Address 7205 Oxford Rd.

17 (a) Burial (b) Date thereof 3/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Mills Md.
(Date rec'd by registrar) Registrar

MAR 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18, 1946, 10:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1932 to March 1946 and that I last saw him alive on March 16 1946.

Immediate cause of death Cerebral hemorrhage
Due to Arteriosclerosis and hypertension.
Due to
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Thacher M. D.
Address 10 W. Saratoga Date signed 3/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G3854 / 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LYDIA BURROWS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Austin S. Burrows
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1893

8. AGE: Years	Months	Days	If less than one day
53	0	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Oliver Linthicum
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Glenn
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Austin S. Burrows
(b) Address 1720 N. Broadway

17 (a) Burial (b) Date thereof 3/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received (year) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1945 to March 18 1946, and that I last saw he/she alive on March 17 1946.

Immediate cause of death	Duration
(a) myocardial insufficiency	4 hrs.
Due to (b) Coronary occlusion	Yrs.
Due to (c)	
Other Conditions Essential hypertension	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. C. Bothwell
Address 447 N. Kenwood Ave. Date signed 3/19/46.

G38.5[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G38.5[illegible]

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Lake Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Lake Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Fischer

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry Fischer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1890

8. AGE: Years	Months	Days	If less than one day
55	9	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Muth
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Acker
15. Birthplace Germany

16 (a) Informant Mr. Henry Fischer
(b) Address 2102 Lake Ave.

17 (a) Burial (b) Date thereof 3/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Ave.

MAR 20 1946
(Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Mar 18 1946 and that I last saw h[illegible] alive on Mar. 18 1946.

Immediate cause of death — Carcinoma of Rectum — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 10, '46

Major findings of operation: Carcinoma of rectum

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Denegre M. D.
Address 4808 Harford Rd. Date signed 3/20/46

VS 150

X

G38543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G38543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: President Hosp. 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Pennsylvania Ave (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William H. Anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Lurena

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	24	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Lurena Anderson
(b) Address 865 Watts Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946, at 10 50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 19 1946

VS 151

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

638544 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 North Monroe Street
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 North Monroe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL L. KELLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Charlotte L. Kelly
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) August 14, 1888

8. AGE: Years	Months	Days	If less than one day
57	7 6	3	********** hr. min.

9. Birthplace Baltimore?, Maryland
(Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Baltimore & Ohio R.R.

FATHER
12. Name John J. Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Caranne McGrath
15. Birthplace Ireland

16 (a) Informant Mrs. Charlotte L. Kelly
(b) Address 21 N. Monroe Street

17 (a) Burial (b) Date thereof 3/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Dorsey, Maryland

18 (a) Funeral director L. B. Waltjen & Son
(b) Address 1300 Eutaw Place

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MAR 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 March 1946 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1946 to 3/17 1946, and that I last saw him alive on 1946

Immediate cause of death: Pneumonia, Lobar-Left. Myocardial Failure.

Duration: 5 days, 1 day.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth L. Bogorad M. D.
Address 1905 W. Baltimore St. Signed 3/ /46

Dr. Bogorad

G38545 — BALTIMORE CITY HEALTH DEPARTMENT — G38545

CERTIFICATE OF DEATH 95c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 [illegible] George [illegible]
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 [illegible] George [illegible]
(If no street, give location)
(e) Citizen of foreign country? R (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Collick Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Bryan Scott
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 7/17/1897

8. AGE: Years 48 | Months 7 | Days 29 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Robt. Toynes
13. Birthplace Va

MOTHER
14. Maiden Name Emma Taylor
15. Birthplace Md

16 (a) Informant Bryan Scott
(b) Address 603 George [illegible]

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/20/1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 3[illegible] W. Schroeder St

19 (a) MAR 20 1946 (Date rec'd by registrar) (b) [illegible] Washington Williamsport, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/46 19 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17/45 to 3/16/46, and that I last saw h[illegible] alive on 3/16/46.

Immediate cause of death Pulmonary Embolism — Duration: 1 hr

Due to Heart Attack — 2 days

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. C. Ellis M. D.
Address 92 W Main Date 3/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1402

638546 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 460 Offard Court (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Williams

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: N
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1912

8. AGE: Years 33 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Charles Co., Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Richard Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Mathilda Miller
15. Birthplace md.

16 (a) Informant Henry Williams
(b) Address 460 Offard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Carolide St.

19 (a) MAR 20 1946 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1946 at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1946 to 3-17 1946, and that I last saw h[illegible] alive on 3-17 1946.

Immediate cause of death	Duration
Septicemia	
Due to Infected abortion	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Harris/Jr M. D.
Address Provident Hosp. Date signed 3-17-46

X

VS 150

G38547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G38547 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave Rukeland St

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (If outside city or town limits write RURAL and give town)

(d) Street No. 1508 N. Bethel St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Keinig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Joseph L Keinig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 - 1890

8. AGE: Years 55 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None —

11. Industry or business

FATHER 12. Name John Nikol

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Schroefer

15. Birthplace Germany

16 (a) Informant Charles J. Keinig

(b) Address 1508 N Bethel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery

Location Belair Rd

18 (a) Funeral director Kendall & Humphreys

(b) Address 4067 Harford Rd

19 MAR 20 1946 Hunting for Williams, M.D. Registrar

Where and when buried or removed

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946 at 10:25 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/1946 to March 18 1946 and that I last saw h[er] alive on March 18 1946

Immediate cause of death Shock +

Toxemia

Duration Acute illness 2 weeks

Due to Perforation of bowel (Cecum)

Due to Obstruction from bowel Carcinoma (sigmoid)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/14/46

Major findings of operation: Distended bowel from obstruction

of autopsy: Carcinoma of sigmoid

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alberto Adams

Address West Baltimore General Hospital Date signed 3/19/46

VS 150

G38548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/97

G38548 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Park Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Rachel Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. ~~Sex~~ Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Percy T. R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1881

8. AGE: Years 65 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER 12. Name Thomas Bell

13. Birthplace Prince George Co. Md

MOTHER 14. Maiden Name Mary Burroughs

15. Birthplace Shepherdstown W Va

16 (a) Informant Percy T. R. Dorsey

(b) Address 1125 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22, 1946 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 1681 Druid Hill Ave.

MAR 20 1946 (Date rec'd by registrar) Courtesy for Williams & Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17-1946, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1946 to 3-17-1946 and that I last saw her alive on 3-17-1946

Immediate cause of death	Duration
Generalized arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.

Address 718 Dolphin St. Date signed 3-19-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38549 LONIE WILSON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G38549 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 Bevans St.
(c) Hospital or institution: no

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore Md.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Bevan St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lonie Wilson

3 (b) If veteran, name war no

3 (c) Social Security Account No. 212-16-479

4. Sex Male | 5. Color or race C. C. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jenie Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1892

8. AGE: Years 54 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Littleton N. Carolina (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business R.R.

MOTHER / FATHER
12. Name Elijah Wilson
13. Birthplace Littleton N. C.
14. Maiden Name Rebecca Wilson
15. Birthplace Littleton N. C.

16 (a) Informant Jenie Wilson
(b) Address 909 Bevan St

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-18, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemty
Location Balto.

18 (a) Funeral director Walter B. Zanger
(b) Address 139 W. Hamburg St.

19 3-18-1946 (Date rec'd by registrar) (b) Herrington for Williams, M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 11 1946 to Mar. 19 1946. and that I last saw him alive on Mar. 17 1946

Immediate cause of death: Acute Lobar Pneumonia — Duration: 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Shelton M. D.
Address 908 S. Mary St Date signed 3/21/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38550 — BALTIMORE CITY HEALTH DEPARTMENT — G38550

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Horner

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-05-4639

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1874

8. AGE: Years	Months	Days	If less than one day
71	11	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Gen'l Electric Co
11. Industry or business Retired

FATHER
12. Name Charles Horner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Kate Krumpert
15. Birthplace Baltimore Md.

16 (a) Informant Annie Horner
(b) Address 109 S. Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belair Rd.

18 (a) Funeral director John J. Nolan
(b) Address 3600 E. Baltimore St.

19 (a) Filed MAR 20 1946 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1946 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.
Date signed 3-19-46

G38551 G38551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 Greenleaf road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5500 Greenleaf road
(If rural give location)
(e) If foreign born, how long in U. S. A.? NO years

3. (a) FULL NAME JOHN THOMAS MANLEY

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Royston Manley
6 (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) Dec. 9, 1897
8. AGE: Years 48 | Months 3 | Days 9 | If less than one day ..... hr. ..... min.
9. Birthplace Holyoke, Mass (Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Thomas Manley
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Ann Reynolds
15. Birthplace Ireland

16 (a) Informant Mrs. Elizabeth Royston Manley
(b) Address 5500 Greenleaf road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 118 N. Mt. Royal Ave

MAR 20 1946 (Date received by Registrar) per Walter for Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946, at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945 to Mar 18 1946, and that I last saw h..... alive on Mar 17 1946.

Immediate cause of death	Duration
Rosomary Thrombosis	2 mon
Due to Arteriosclerosis	
Cardiovascular Renal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James H Howard M. D.
Address 718 Frederick Rd Date signed 3-19-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G38552 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Greenmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kate Whitehouse Mil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1876

8. AGE: Years	Months	Days	If less than one day
69	11	7	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business Grinnel Co.

FATHER
12. Name Charles W. Miller
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Nellie Stine
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. K. Whitehouse Miller
(b) Address 3604 Greenmount Ave.

17 (a) Removal (b) Date thereof 3/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fernwood Cemetery
Location Philadelphia, Pa.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) Filed by registrar Washington Williams, M Registrar
MAR 20 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1946, at 9.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to March 19 1946, and that I last saw h[illegible] alive on March 10 1946.

Immediate cause of death Carcinoma of Neck — Duration 1 yr?

Due to Branchial cleft cyst

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. S. J. Ramanco M. D.
Address 436 E Fort Ave Date signed 3/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G38553 — BALTIMORE CITY HEALTH DEPARTMENT — G38553 Registered No.

CERTIFICATE OF DEATH 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 W. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 W. Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BELINDA M. LEACH

3 (b) If veteran, name war	3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Hiram A. Leach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	3	hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Williamson
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Hiram A. Leach
(b) Address 2323 W. Mosher St.

17 (a) Burial (b) Date thereof 3/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 20 1946 — Washington Williams, M.D. — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1946, at 1.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1946 to March 19 1946 and that I last saw her alive on March 18 1946

Immediate cause of death: Rheumatic Heart Disease — Duration unknown

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Nathan Rosen
Address 206 S. Gilmor Date si

95B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G38554
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Homer T. Blanch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Clara A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1890.

8. AGE: Years	Months	Days	If less than one day
55	8	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Baltimore City Fire Dept.

FATHER
12. Name Homer T. Blanch
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Fleming
15. Birthplace Md.

16 (a) Informant Mrs. Clara A. Blanch
(b) Address 2113 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director Harry H. Whittle
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MAR 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946 to 3/18 1946 and that I last saw him alive on 3/18 1946

Immediate cause of death Carcinoma of Rectum — Duration Aug-45

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Cahn

Address 2145 N Balto St. Date signed 3/ M. D.

X

G38555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

G38555 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4216 Hickford Rd
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 y
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4216 Hickford Rd
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME James Craig McLanahan

3 (b) If veteran, name war 1st World War

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Linda M. Lanahan

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) April-28-1881

8. AGE: Years 64 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Insurance Lawyer

11. Industry or business —

FATHER 12. Name Saml McLanahan

13. Birthplace Pa.

MOTHER 14. Maiden Name Maud Lombie

15. Birthplace Pa

16 (a) Informant Mrs J. C. McLanahan (wife)

(b) Address 4216 Hickford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Emmitsburg, Md

18 (a) Funeral director Edward Moran Co.

(b) Address 10 E Lexington Ave

19 (a) 1946 (b) Filed by Washington Williams, M Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 1946, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Mar 1946 and that I last saw h[illegible] alive on Mar 19 1946.

Immediate cause of death	Duration
Cardio-vascular-renal failure	1 yr 6 mos
Due to Hypostatic pneumonia and generalized arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Franklin E. Lutes
Address 1116 St Paul Date signed 3/20/46.

G38556 BALTIMORE CITY HEALTH DEPARTMENT G38556

CERTIFICATE OF DEATH 92 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-E. Chase St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 11'
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11-E Chase St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence Watson Wheelwright

3 (b) If veteran, name war — no —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Martha C. Wheelwright

6 (c) If alive, give age —, ? years

7. Birth date of deceased (mo., day, yr.) Nov-23-1901

8. AGE: Years 44 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Washington DC.
(town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER 12. Name Jere H. Wheelwright
13. Birthplace Virginia

MOTHER 14. Maiden Name Eleanor Ould Fox Stephenson
15. Birthplace Maryland

16 (a) Informant Mr. Jere H. Wheelwright Jr.
(b) Address 1 Upton Monticello Pl.

17 (a) Cremation (b) Date thereof 3-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart Mayne Co.
(b) Address 108 W. Mt. Royal Ave.

19 (a) (Filed by registrar) (b) Harrington Williams M.D. Registrar

MAR 20 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18 1946, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Mar. 18 1946.
and that I last saw h— alive on Mar 18 1946

Immediate cause of death Probable Pulmonary embolus

Due to Rheumatic heart disease with mitral stenosis + insufficiency

Due to with chronic decompensation

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operations

Autopsy:

Duration
10 yrs +

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Franklin E. Leslie

Address 1115 St Paul Date signed 3/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38557 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 S. LAKEWOOD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 S. LAKEWOOD AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA MAXWELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JOHN E. MAXWELL.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 25 1884

8. AGE: Years	Months	Days	If less than one day
62	0	21	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE AT HOME
11. Industry or business

FATHER
12. Name JOSEPH ADAMS
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO. MD.

16 (a) Informant JOHN MAXWELL (HUSBAND)
(b) Address 635 S. LAKEWOOD AVE.

17 (a) BURIAL (b) Date thereof MAR. 21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL CEM.
Location ODONNELL ST.

18 (a) Funeral director Leikly & Seiler Inc.
(b) Address 403 S. WOLFE ST.

MAR 20 1946
(Date rec'd by registrar)

(a) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 18 1946, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1946, to March 19 46
and that I last saw h[illegible] alive on March 19 46

Immediate cause of death: Coronary Thrombosis — Duration: One Day
Due to: Arteriosclerosis — 3 Yrs
Due to:
Other Conditions: Hypertension — 3 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Leo J. Kalacka M. D.
Address 126 S. [illegible] Date signed March 24/46

VS 150

G38558 BALTIMORE CITY HEALTH DEPARTMENT X G38558

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Peter A. Dutrich C.S.S.R.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/24/68
8. AGE: Years 77 Months 11 Days 25 If less than one day min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO. MD.

16 (a) Informant Rep. Marian County
(b) Address Elchester, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Elchester Md

18 (a) Funeral director Lilly + Zeile Inc
(b) Address 410 E. Lafayette

19 (a) MAR 20 1946 (Date rec'd by registrar) (b) for Williams, M. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1946, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1946 to 3/19 1946 and that I last saw h[illegible] alive on 3/19 1946.

Immediate cause of death: Cardio-respiratory failure — Duration
Due to: Hypostatic pneumonia
Due to: Cardio vascular disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Cyd Jr
Address St Josephs Hospt Date signed 3/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38559 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 S Newkirk St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 S Newkirk St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Domonick Kausch

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife EVA KAUSCH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.25 1884

8. AGE: Years	Months	Days	If less than one day
62 61	1	24	hr. min.

9. Birthplace ROMANIA (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business FOR SELF

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ?

16 (a) Informant EVA KAUSCH (WIFE)
(b) Address 510 S.NEWKIRK ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR.22/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Leibly & Zeiler Inc.
(b) Address 403 S.WOLFE ST.

19 (a) MAR 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 March 1946 at 6 30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kefauver M.D.
Date signed 18 March 46 Medical Examiner.

S-38560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

S-38560 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 741 S. Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard (Lengerman) Lingerman

3 (b) If veteran, name war W.W.# 2

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 10 1909 (1939)

8. AGE: Years 37 | Months 0 | Days 9 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation COAL TRUCK DRIVER

11. Industry or business

FATHER
12. Name HENRY (LENGERMAN) Lingerman
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name BESSIE HENNINGER
15. Birthplace BALTO. MD.

16 (a) Informant BESSIE (LENGERMAN) Lingerman (MOTHER)
(b) Address 741 S. LUZERNE AVE.

17 (a) BURIAL (Burial, cremation, removal)
(b) Date thereof MAR. 22/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. [redacted]
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Geiselmer
(b) Address 403 S. WOLFE ST. Huntington Williams, M.D.

19 MAR 20 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-1946, at 11 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/19/46 at 10:10 A.M. 6/1
(b) Where did injury occur? Fairmount & Linwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Collision of two trucks

23. Signature Robert L. Fraher M.D.
Medical Examiner.
Date signed 3-19-46

VS 151

X

BE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The ...e is especially important. Physicians: please write the causes of death clearly and legibly.

G38560 G38560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 EUTAW PLACE
(c) Hospital or institution:
NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 S.CLINTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES J.KERN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: MARGARET KERN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC.21 1867

8. AGE: Years	Months	Days	If less than one day
78	2	28	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation RETIRED ENGINEER
11. Industry or business

FATHER
12. Name MATHIAS KERN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant ANTHONY KERN (SON)
(b) Address 1111 S.CLINTON ST.

17 (a) BURIAL (b) Date thereof MAR.21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Eilly & Geiler inc
(b) Address 403 S.WOLFE ST.

MAR 20 1946
(Date rec'd by registrar)
(b) [illegible] Williams M.D.
Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH MAR. 18 1946 at 4/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 1946 to 3-17 1946, and that I last saw h[illegible] alive on 3-17 - 1946.

Immediate cause of death — Duration

Coronary Insufficiency

Due to Adv. atherosclerosis

Due to

Other Conditions Chr. nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Gaish M. D.
Address 1700 Eutaw Pl. Date signed 3-19-46

VS 150

X

G38562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38562

Registered No. 1218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Lemmon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Lemmon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Leo H. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1867.

8. AGE: Years	Months	Days	If less than one day
78	7	11	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mathias Wolf
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16. (a) Informant Joseph W. Miller (Son)
(b) Address 1907 Lemmon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Kirkpatrick
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) Huntington Mills, Md. Registrar

MAR 20 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/46 19 , at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to March 17 1946 and that I last saw h[illegible] alive on March 17 1946

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1724 W Lombard St Date signed 3/19/46

935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G38563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Mc Guire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife 1918

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace Wayland, Ky
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Henry Mc Guire
13. Birthplace Ky

MOTHER
14. Maiden Name Everetta Wright
15. Birthplace Va.

16 (a) Informant Clark Funeral Home
(b) Address Ashland, Ky.

17 Burial (b) Date thereof 3/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Helens
Location St Helens Ky

18 (a) Funeral director Williams Coffey Inc
(b) Address 1217 Front St.

19 (a) (Date received by local registrar) MAR 21 1946 Huntington Williams, M.D. Registrar

VS.151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946, at 9 20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 19 1946 1 20 A.M.
(b) Where did injury occur? 1703 Linden Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot

23. Signature Robert Lee Gratacap M.D.
Medical Examiner
Date signed March 19 1946

G38564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G38564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 W. 26th St.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 W. 26th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert S. Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie G. Hamilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28th 1877

8. AGE: Years 68 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Towson Md.
(Town, county, and state)

10. Usual Occupation Driver

11. Industry or business American Ice Co

FATHER
12. Name Geo. W. Hamilton
13. Birthplace Unknown

MOTHER
14. Maiden Name Laura E. "
15. Birthplace "

16 (a) Informant Carrie G. Hamilton
(b) Address 425 W. 25th St

17 (a) Burial (b) Date thereof 3/22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Woodlawn, Md

18 (a) Funeral director Williams Cook Co
(b) Address 217 E Pleasant Street

19 (a) Filed (month) (day) (year) (b) Registrar

MAR 21 1946 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th 1946 at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease.

Due to Arteriosclerosis.

Other Conditions Myocardial degeneration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard S. Williams M.D.
Medical Examiner.
Date signed 3-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638565 BALTIMORE CITY HEALTH DEPARTMENT 638565

CERTIFICATE OF DEATH 1170 C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 E. Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Mitchener Downey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Separated

6 (b) Name of husband or wife Arthur Downey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
41 40			hr. min.

9. Birthplace Selma, N. C.
(Town, county, and state)
10. Usual Occupation Operator
11. Industry or business

FATHER
12. Name O. B. Mitchener
13. Birthplace N. C.

MOTHER
14. Maiden Name Louisa Bennett
15. Birthplace N. C.

16 (a) Informant O. B. Mitchener
(b) Address Selma North Carolina

17 (a) Burial (b) Date thereof Mar. 22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Raleigh, N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) MAR 21 1946 Register [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 7A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage, traumatic C
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 5/29
(a) Date of injury March 16, 1946 1:30 P.M.
(b) Where did injury occur Orleans & Forrest Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Fell - struck by auto

23. Signature Robert Lee Stratton M.D.
Medical Examiner.
Date signed 3-29-46

VS 151

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38566 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Westwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Westwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED E. ELWELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Delia B. Elwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1877

8. AGE: Years	Months	Days	If less than one day
69	2	7	hr. min.

9. Birthplace Lakewood, Ohio (Town, county, and state)
10. Usual Occupation Sea Captain
11. Industry or business

FATHER
12. Name Alfred Elwell
13. Birthplace Lakewood, Ohio

MOTHER
14. Maiden Name Mary Phelps
15. Birthplace Rocky River, Ohio

16 (a) Informant Mrs. Delia B. Elwell
(b) Address 3111 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md/

19 (a) (Date rec'd by registrar) (b)

MAR 21 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19, 1946, at 6:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1946, to March 19 1946, and that I last saw h[illegible] alive on 19 March 1946.

Immediate cause of death: Chronic suprarenal degeneration with decompensation and failure — Duration: years.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lexington L. Kenan M.D.
Address 1938 Linden Ave Date signed 3/20/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Chelsea Terr. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA K. FERGUSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ralph S. Ferguson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1889

8. AGE: Years	Months	Days	If less than one day
57	1	16	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edwin Knowles
13. Birthplace Balto.

MOTHER
14. Maiden Name Annie Bowen
15. Birthplace Wash., D. C.

16 (a) Informant Mrs. Paul Towson
(b) Address 2903 Lyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 21 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19/1946, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11/1946 to 3/19/1946, and that I last saw h. alive on 3/19/1946

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic cardiovascular disease	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Cook M. D.
Address Univ. Hosp. Date signed 3/21/46

935

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38568 — 1312 — G38568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3332 Mondawmin Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3332 Mondawmin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: CHARLES W. BADER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mattie H. Bader nee Gabriel
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	24	hr. min.

9. Birthplace: Baltimore
(Town, county, and state)
10. Usual Occupation: Commission Business
11. Industry or business: (retired)

FATHER
12. Name: Henry Bader
13. Birthplace: Germany

MOTHER
14. Maiden Name: Wimmer
15. Birthplace: U. S.

16 (a) Informant: Mrs. Mattie H. Bader
(b) Address: 3332 Mondawmin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/22/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 21 1946 (Date rec'd by registrar) (b) Clinton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1946, at M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to March 20 1946. and that I last saw h[illegible] alive on March 20 1946.

	Duration
Immediate cause of death: Cardiac Asthma	1 hour
Due to: Arteriosclerosis	5 yrs
Due to: Hypertension, nephritis	5 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Edw Coon M.D.
Address: 1202 St Paul St Date signed: 3/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c G38[illegible] Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 66 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 White Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Clarence Kable

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-5770

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Esther G. Kable
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1897

8. AGE: Years	Months	Days	If less than one day
48	3	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Checker
11. Industry or business Standard Oil Co.

FATHER
12. Name Clarence C. Kable
13. Birthplace Kabletown, W. Va.

MOTHER
14. Maiden Name Ida M. Miller
15. Birthplace Jefferson Co.

16 (a) Informant Mrs. H. Esther Kable
(b) Address 4504 White Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MAR 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1946, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull Fracture + intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-18-46 at 26/6 Oil 5:45 A M.
(b) Where did injury occur? Standard Oil 1423 S. Clinton St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes
(d) Means of injury Fell from top of tank

23. Signature Benedict Skotnicki M.D.
Medical Examiner.
Date signed 3-20-46

G38570 — Lr. John G38570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 E. 22½ Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 E. 22½ Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillie Tilghman

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1905

8. AGE: Years 41 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Henry Moses
13. Birthplace Maryland

MOTHER — 14. Maiden Name Harriet Lang
15. Birthplace Maryland

16 (a) Informant Virgie Jones
(b) Address Cambridge Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County

18 (a) Funeral director Haynes Sanders
(b) Address 1412 E. Preston Street

19 (a) (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MAR 21 1946

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 19 1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 15 1946 to Mch 19 1946 and that I last saw h[illegible] alive on Mch 19 1946

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 2329 Guilford Ave Date signed Mch 20 1946

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

638571

CERTIFICATE OF DEATH √1640

Registered No. 638571

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Belgian Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Belgium Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Helen Webb

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1923

8. AGE: Years	Months	Days	If less than one day
22	9	17	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk at
11. Industry or business Petrol Co.

FATHER
12. Name John F. Webb
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Helen Spellman
15. Birthplace Baltimore Md.

16 (a) Informant John F. Webb
(b) Address 701 Belgian Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22/46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave & Longwood St

18 (a) Funeral director Elmer W. Corbin & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1946 at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation by hanging.

Due to Mental Despondency.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/19/46 at P. M.
(b) Where did injury occur? 701 Belgian Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanged self

23. Signature Benedict Skiatelis M.D. Medical Examiner.
Date signed 3-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G38572 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 Forrest st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rocco Cusato

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-6990

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eleanore Salvi
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1887

8. AGE: Years	Months	Days	If less than one day
59	2	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Track Foreman
11. Industry or business P. R. R.

FATHER
12. Name Nicholas Cusato
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Cortez
15. Birthplace Italy

16 (a) Informant Mr. Nicholas R. Cusato (son)
(b) Address 1031 Forrest Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4430 Belair Road

18 (a) Funeral director Ebenezer W. Conaway & Son
(b) Address 924 E. Lexington Street

19 (a) Received by Registrar (b) Registrar Lavigne Williams, M.D.

MAR 21 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-1946, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage

Due to

Other Conditions Contusions rt. chest, Laceration rt. ear.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1-46 at 5:30 P.M.
(b) Where did injury occur? Orleans & East St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto.

23. Signature Benedict DeStefano M.D. Medical Examiner.
Date signed 3-20-46

G38573 ✓ G38573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 Worsley St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 Worsley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Haskins

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) ~~Name~~ of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/90

8. AGE: Years 57 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Cotton
11. Industry or business

FATHER
12. Name John Haskins
13. Birthplace Va

MOTHER
14. Maiden Name Ellen Scott
15. Birthplace Va

16 (a) Informant Mary E. Haskins
(b) Address 430 Worsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A & Co Rd

18 (a) Funeral director Robert Williams
(b) Address 1515 McCulloh St

MAR 21 1946 (Date rec'd) (b) Huntington Williams (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16- 1946, to 3-19- 1946 and that I last saw h/M alive on 3-16- 1946.

Immediate cause of death: Hypostatic Congestion Cardio Renal Disease — Duration: 2 yrs
Due to
Due to
Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin Adams, M. D.
Address 312 E 23rd St Date signed 3-20-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

✓ G38574 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue 25-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 Tate Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Turner H. Lispacomb

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-65-2780

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Servancia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/81

8. AGE: Years 65 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Bismere, Ala. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Grand Lispacomb
13. Birthplace Alabama

MOTHER
14. Maiden Name Laura ?
15. Birthplace Alabama

16 (a) Informant Mrs. S. Lispacomb
(b) Address 3320 Tate Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co, Md.

18 (a) Funeral director Robert E. Williams
(b) Address 515 McElderry St

19 (a) (Signature of local registrar) (b) (Registrar)
MAR 21 1946 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1946, at 9 45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D. (Medical Examiner)
Date signed 3/21/46

X

G38575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G38575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution: Fair Wath Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leah Adleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name — Abarnal
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs. Helen Adleman
(b) Address 3413 Harrington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-46 (month) (day) (year)

(c) Cemetery or crematory Southern Ave.
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto. St

19 MAR 21 1946 (Date received) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-46 19 , at 6 20 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 13, 1942 to March 19, 1946, and that I last saw her alive on March 18, 1946.

Immediate cause of death: Chronic Myocarditis — Duration 2 yrs.

Due to Arteriosclerotic Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Adleman

Address 1331 S. Kenwood Ave Date signed 3-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38576 BALTIMORE CITY HEALTH DEPARTMENT G38576

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 Quantico Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Quantico Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Diamond

3 (b) If veteran, name war

3 (c) Social Security Account No.?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife Bertha Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Annie
15. Birthplace Russia

16 (a) Informant Wife
(b) Address 2609 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1434 E. Balto. St.

19 (a) MAR 2 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21-19 46 at 1 15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Contusion of Brain
Subarachnoid Hemorrhage
Due to marked

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-21-46 at 1:15 A.M. 15/13
(b) Where did injury occur? 2609 Quantico Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fell down stairs

23. Signature Benedict Shatzkin M.D. (Medical Examiner)
Date signed 3-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL 83727
G38577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G38577 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 6 - 10 18
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 12
(d) Street No. 1216 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Barnes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1921

8. AGE: Years 24 | Months 11 | Days 26 27 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Laurence Saunders
13. Birthplace S. C.

MOTHER
14. Maiden Name Nellie Fleming
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Skipped (Burial, cremation, or removal) (b) Date thereof March 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Florence S. C.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) MAR 21 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946, at 7.02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9, 1943, to Mar. 19 1946, and that I last saw her alive on March 19 1946

Immediate cause of death	Duration
Amyloidosis	2
Due to	
Due to	
Other Conditions Pulmonary Tuberculosis Tuberculous Enteritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cause

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Copeland M.D.
Address Baltimore City Hospitals Date signed 3/20/46

66B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 638178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11mos- 23days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3- 1928

8. AGE: Years 17 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Green
13. Birthplace Md.

MOTHER
14. Maiden Name Viola Johnson
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 377 N. Schroeder St.

19 (a) MAR 21 1946 (Date rec'd by registrar) Registrar
Mrs. Katie R. Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946 at 11.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26- 1945 to 3-19 1946 and that I last saw her alive on 3-19- 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other Conditions Pott's disease & Hypertensive Heart (Include pregnancy within 3 months of death)	2 yrs.

Date of operation
Major findings of operation:
of autopsy: Cavities, Pott's disease, pulm. edema, chronic Heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Carroll
Address Balto City Hosp. Date signed Mar 20 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G38579

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Plymouth Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M Braund

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Anna A. Steffler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5- 1888

8. AGE: Years	Months	Days	If less than one day
57	11	14	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Draftsman Mechanical

11. Industry or business B & O.

FATHER
12. Name Wm. Braund
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Dumont
15. Birthplace England

16 (a) Informant Edward A. Russell
(b) Address 629 Plymouth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 22/46 (month) (day) (year)
(c) Cemetery or crematory Pa. Du Bois Cem
Location Du Bois Pennsylvania

18 (a) Funeral director John O. Mitchell Home
(b) Address 1700 Eutaw Place

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by reg.)

MAR 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th 1946, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 11th 1946, to March 19th 1946, and that I last saw h. alive on March 19th 1946.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Myocarditis	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Smedley M.D.

Address U. S. Hospital Date signed M. 3 D. 19/46

X

G38580

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38580 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d. min.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 863 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Walter Thomas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. ? 1910

8. AGE: Years	Months	Days	If less than one day
35 36	7 6	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry B. Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen K. Cole
15. Birthplace Maryland

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

19. (a) MAR 21 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 19 46 at 9 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 19, 1946 19, and that I last saw him alive on Mar. 19 19 46.

Immediate cause of death	Duration
Coronary occlusion with myocardial infarction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kilpatrick, Jr. M.D.
Address Union Memorial Hosp. Date signed 3-19-46.

X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638.581 unrepeated BC# 960119 ✓

490135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

638581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Walter Williams
13. Birthplace md.

MOTHER
14. Maiden Name Alice King
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/ /46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 2345 Kelford Rd.

MAR 21 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1946 to March 20 1946 and that I last saw him alive on March 20 1946.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Garrison Jr. M.D.
Address Johns Hopkins Hosp. Date signed 3/20/46

X

G38582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G38582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene Street
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Glenmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Ramming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Margaret A. Ramming
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1866

8. AGE: Years	Months	Days	If less than one day
79	5	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Christian Ramming
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Lauterlack
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Ramming
(b) Address 3105 Glenmore Avenue

17 (a) Burial (b) Date thereof 3/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road
19 (a) (b) Huntington Woods, Md.
(Date rec'd by registrar)

MAR 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1946, to 3/20 1946, and that I last saw him alive on 3/20 1946.

Immediate cause of death	Duration
Due to Coronary occlusion	
Due to	
Other Conditions Complete heart block - intermittent rhythm	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sara Cook M. D.
Address Univ. Hosp. Date signed 3/21/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38583 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Greenmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Alexander Slaysman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1880

8. AGE: Years	Months	Days	If less than one day
65	8	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired Butcher
11. Industry or business

FATHER
12. Name Mehlon Slaysman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ann Joseph
15. Birthplace Md.

16 (a) Informant Charles Slaysman
(b) Address 3038 Greenmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) APR 5 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 19 46 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-46 19 to 3-20-46 19, and that I last saw him alive on 3-20-46 19

Immediate cause of death: Cardio-respiratory failure.

Due to: Hypertensive arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Ryder M.D.
Address St. Joseph's Hosp. Date signed 3/20/46

(B-98752-1) 638544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Markley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Sommers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elsie B. Sommer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1879

8. AGE: Years	Months	Days	If less than one day
66	10	3	hr. min.

9. Birthplace Md. Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Safety Engineer
11. Industry or business

FATHER
12. Name Charles Sommers
13. Birthplace Pa.

MOTHER
14. Maiden Name Rebecca Hall
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) MAR 0 (Do not write; duty registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946, at 12.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7- 1946 to 3-19- 1946 and that I last saw him alive on 3-19- 1946

Immediate cause of death	Duration
Coronary Occulsion.	
Due to Arteriosclerotic Heart Disease.	
Due to	
Other Conditions Bronchopneumonia. Resolved. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: Coronary Occulsion.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fauber M.D.
Address Balt. City Hosps. Date signed 3-20-46

VS 150

X

The G38585

BALTIMORE CITY HEALTH DEPARTMENT

HB # 99798

CERTIFICATE OF DEATH

159

Registered No. G38585

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Flicker Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jenkins Baby Boy -or- Jennings Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1946

8. AGE: Years 6 days | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Balto. City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 3-19-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crematory
Location Baltimore City Hospitals

18 (a) Funeral director
(b) Address

19 (a) Date rec'd MAR 21 1946 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946; at 5:04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9, 1946 to March 14, 1946 and that I last saw him alive on March 14, 1946

Immediate cause of death Aspiration of stomach contents into lungs — Duration

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George L Palmer

Address Baltimore City Hosp. Date signed 3-25-46

X

G38586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 513

Registered No. G38586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison and Howard Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 306
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George V. Zack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1873

8. AGE: Years 72 | Months 11 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Hungary (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Zack
13. Birthplace Hungary

MOTHER 14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Rose M. Preston
(b) Address 336 Edmund St. Aberdeen

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Mar. 21-46 (month) (day) (year)

(c) Cemetery or crematory
Location Fairmount Cem.

18 (a) Funeral director John Tarring
(b) Address Aberdeen, Md.

19 (a) Filed by registrar MAR 21 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1946, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1946 to 3-21 1946 and that I last saw him alive on 3-21 1946.

Immediate cause of death Circulatory Collapse — Duration

Due to Hemorrhage, shock (post operative) —

Due to Carcinoma of prostate —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 3-20-46

Major findings of operation: Ca of prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carlton Benefield M. D.
Address Md. Gen. Hosp. Date signed 3/21/46

X

G38587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122Q

G38587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Liberty St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 E. Preston Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Marie Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1946

8. AGE: Years | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Shelby Boyd
13. Birthplace: Tennessee

MOTHER
14. Maiden Name: Virginia Sorrentino
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Shelby Boyd
(b) Address: 1107 E. Preston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) (b) Huntington Williams, M.D.

MAR 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1946 at 2:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4 1946 to 3/21 1946, and that I last saw him alive on 3/21 1946

Immediate cause of death: Respiratory failure — Duration:

Due to: Aspiration pneumonia

Due to: Obstruction in upper G.I. tract

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Robinson M. D.
Address Univ. Hosp. Date signed 3/21/46

VS 150

X

G38588 — BALTIMORE CITY HEALTH DEPARTMENT — G38588 Registered No.

CERTIFICATE OF DEATH

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 E.27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 E.27th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Barbusca

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~wife~~ late John Barbusca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1881

8. AGE: Years 64 | Months 8 | Days - | If less than one day hr. min.

9. Birthplace Calascibetta Italy (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER: 12. Name Giuseppe Castagna
13. Birthplace Italy

MOTHER: 14. Maiden Name Carmela Pecora
15. Birthplace Italy

16 (a) Informant Joseph Barbusca (Son)
(b) Address 3631 Elkader Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt.Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N.Morley St.

19 (a) MAR 21 1946 (Filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946, at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940, to March 18 1946, and that I last saw her alive on March 18 1946.

	Duration
Immediate cause of death: Cerebral Thrombosis	4 days
Due to: arteriosclerosis	2 years
Due to: diabetes mellitus &	10 years
Other Conditions: old age.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Egbert L. Mortimer Jr. M. D.
Address 2706 St Paul St Date signed 3/19/46

638589 638589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P Lubawski LUBAWSKI
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-31-11
8. AGE: Years 34 | Months 1 | Days 20 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Wilton Lubawski
13. Birthplace Poland
MOTHER 14. Maiden Name Lena ?
15. Birthplace Poland
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (b) Date thereof 3-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City
18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave
19 MAR 21 1946 (b) Huntingtor Williams M.D.
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 2:05 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1945, to Mar. 20 1946, and that I last saw h[illegible] alive on Mar. 20 1946
Immediate cause of death Massive pulmonary infarction — Duration 12 hrs.
Due to Mitral stenosis — 18 mos.
Due to Rheumatic heart disease — 18 mos.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John B. Pelloway
Address Johns Hopkins Hosp Date signed 20th Mar.

VS 150

G38590

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G38590

CERTIFICATE OF DEATH

Registered No. 117B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Sulphur Spring Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Sosnowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-27-1899

8. AGE: Years	Months	Days	If less than one day
47		20	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Frances Sosnowski
(b) Address 2007 Sulpher Spring Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Md

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Av

19 (a) (Date received by registrar) MAR 21 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1946, at 4:23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946, to 3/20 1946, and that I last saw him alive on 3/20 1946.

Immediate cause of death	Duration
Perforated Duodenal Ulcer	17
Due to	
Due to	
Other Conditions Peritonitis	

(Include pregnancy within 3 months of death)

Date of operation March 1st — March 15

Major findings of operation: Perforated Ulcer Duodenum & Peritonitis

of autopsy: Perforated Ulcer Duodenum & Peritonitis Subdiaphragmatic Abscess

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Engelhardt
Address St Agnes Hospital Date signed 3/21/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

184

G38591 ✓

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Hosp 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Carson Hayward.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1930.

8. AGE: Years	Months	Days	If less than one day
15	2 4	18 21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation School.
11. Industry or business

FATHER
12. Name Carson Hayward.
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Mary Evans.
15. Birthplace Somerset Co. Md.

16 (a) Informant Mrs. Mary Hayward.
(b) Address 1840 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46. (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) MAR 21 1946 Received by Local Registrar Huntington Mch Circle, M

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-1946 at 9 50 P. M

21. I certify that I took charge of the remains described above, held an Insp & Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH, Gunshot wound back of neck.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/19/46 at 20/1 9:30 P. M.
(b) Where did injury occur? 525 N. Monroe St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no.
(d) Means of injury Shot with rifle while.

23. Signature Benedict Skiteski Playing M.D.
Medical Examiner.
Date signed 3-20-46

X

Gallo

G38592 ✓ G38592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena (or) Nicolina Gallo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Ferdinand
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 188[illegible]

8. AGE: Years	Months	Days	If less than one day
64	9	16	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Domnick DeSilvio
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Monica
15. Birthplace Italy

16 (a) Informant Domnick Gallo
(b) Address 1318 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director M. & M. E. Degnan Sons
(b) Address Lombard & Aisquith Sts.

19 (a) Filed MAR 21 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946 at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1938 to March 20 1946 and that I last saw her alive on March 19 1946

Immediate cause of death	Duration
Coronary Thrombosis	8 hours
Due to Hypertensive Heart Disease	10 yrs+
Due to	
Other Conditions Left hemiplegia	10 yrs+

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Schneider M. D.
Address 1101 N. Washington Ave Date signed 3-20-46

VS 150

Hunting for Williams, Md.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G38593 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard Green St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 20 months

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town DUNDALK
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7306 SCHOOL AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD J. McDANIEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 9 1944

8. AGE: Years	Months	Days	If less than one day
1	8	11	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JESSIE McDANIEL
13. Birthplace LA.

MOTHER
14. Maiden Name FLORENE JORDAN
15. Birthplace LA.

16 (a) Informant JESSIE McDANIEL(FATHER)
(b) Address 7306 SCHOOL AVE. DUNDALK

17 (a) BURIAL (b) Date thereof MAR. 22/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Tilly's Zeiler Inc.
(b) Address 403 S. Wolfe St. Williams, M

19 (a) (b)
(Signature of Registrar) Registrar

MAR 21 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1946 at 6: P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1946 to March 30 1946 and that I last saw him alive on 3/30 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Central nervous system failure	
Due to meningitis	
Other Conditions Congenital anomalies	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Robinson M. D.
Address University Hospital Date signed 3/30

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

638594 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 East Randall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Randall
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB J. STEVENS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: m | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Minnie Viola Stevens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1894

8. AGE: Years 57 | Months # | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business B&O R.R.

FATHER 12. Name Happy Stevens

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Ellen Twedell

15. Birthplace Unknown

16 (a) Informant MRS. Minnie V. Stevens

(b) Address 426 E. Randall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 22, 1946 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location B.O. Co Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1476 Light St. 30

19 (a) (b) Huntington Williams, M.D.

MAR 21 1946

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19/46 19 , at 8:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(b) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.

Date signed 3/19/46

G38595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G38595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N Calhoun St.
(c) Hospital or institution: Franklin Square Hosp 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5724 Claver Rd. (If rural give location)
(e) Citizen of foreign country? and (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Schiavone

3 (b) If veteran, name war /
3 (c) Social Security Account No. 216-09-3455

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of husband or wife Katherine M. Schiavone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1887

8. AGE: Years	Months	Days	If less than one day
58	7	26	29 hr. min.

9. Birthplace Baltimore Md (Town, County, or State)
10. Usual Occupation Electrical Sheetpacking Co.
11. Industry or business

FATHER
12. Name Pasquale Schiavone
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Magdalene Juliana
15. Birthplace Italy

16 (a) Informant Michael Joseph Schiavone
(b) Address 705 Addecroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3.27.46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

APR 1 1946 Huntington Williams, M.D. (Rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1946, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1945, to 3/18 1946, and that I last saw h[im] alive on 3/18 1946.

Immediate cause of death Cachexia — Duration
Due to Carcinomatosis — over
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1/24/46
Major findings of operation: Metastatic Ca of spinal cord
of autopsy: Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Sq. Hosp. Date signed 3/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G38596 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Harwell Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Harwell Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGDALENA MADER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John V. Mader
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept 28, 1862

8. AGE: Years 83 | Months 5 | Days 20 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Willner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Eva Wehr
15. Birthplace: Germany

16 (a) Informant: Mrs. Margaret Foote
(b) Address: 3205 Harwell Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Huntington-Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 11.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1944 to Mar 20 1946, and that I last saw him alive on 3/20 1946.

Immediate cause of death: Cardio-Vascular Disease
Due to: Senility
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: L. B. Stevens M.D.
Address 3400 Edmondson Ave Date signed 3/20/46

G38597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G38597
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Ensor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Marlyn Ave #21
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Bailey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16 - 1946

8. AGE: Years	Months	Days	If less than one day
—	—	2	— hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert Brown Bailey
13. Birthplace Selma N.C.

MOTHER
14. Maiden Name Billie Katherine Williams
15. Birthplace Kenly N.C.

16 (a) Informant Mrs. Billie Bailey
(b) Address 220 S Marlyn Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 21 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 21 1946 (b) Thurlow Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18 1946, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16 1946, to Mar 18 1946, and that I last saw her alive on Mar 16 1946.

Immediate cause of death	Duration
Probable intra-cranial hemorrhage	
Due to: Congenital hemolytic disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Louis Jorgensen M. D.
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information known must be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 2

3375

638.98

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

638.98 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levendale Home
(c) Hospital or institution: Belvedere & Greenspring Ave 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) 6 or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4523 Pimlivo Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wolf Scheinman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 71 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Wales
(Town, county, and state)

10. Usual Occupation

11. Industry or business Salesman

FATHER
12. Name Samuel Joseph Scheinman
13. Birthplace England

MOTHER
14. Maiden Name Sarah ?
15. Birthplace England

16 (a) Informant Daisy Scheinman
(b) Address 4523 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Helen Herring Rem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAR 22 1946 (Date received by Registrar) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946 at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1946, to 3-21 1946 and that I last saw him alive on 3-21 1946.

Immediate cause of death: Chr card ov disease
Chr Nephritis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Kern M.D.
Address Levendale Date signed 3/21/46

X

G38599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G38599
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 E. 41st. ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Martin Thoms

3 (b) If veteran, name war: NL
3 (c) Social Security Account No. NONE
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 13th 1937
8. AGE: Years 8 | Months 7 | Days 7 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business Public School

FATHER
12. Name Walter E. Thoms
13. Birthplace Milwaukee Wis.

MOTHER
14. Maiden Name Frances Martin
15. Birthplace Balto. Md.

16 (a) Informant Walter E. Thoms
(b) Address 721 E. 41st St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 22 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20- 1946, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage.

Due to

Other Conditions Intra abdominal injuries.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-20-46 at 9/1 A. P. M.
(b) Where did injury occur? Regnere + Northern
(c) Did injury occur at home, on farm, industrial place, or public place? Public While at work? No.
(d) Means of injury Struck by auto while riding

23. Signature Benedict Skutarski Biegel M.D.
Medical Examiner.
Date signed 3/21/46

VS 151

G38600 — Cropsey ✓ — G38600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Cliftview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Lucy Cropsey

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William C. Cropsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28th 1870

8. AGE: Years 76 | Months 0 | Days 22 20 | If less than one day hr. min.

9. Birthplace Charles Town W. Va. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER — 12. Name James D. Hackley
13. Birthplace Va.

MOTHER — 14. Maiden Name Jane Jenkins
15. Birthplace Va.

16 (a) Informant George Cropsey
(b) Address 1901 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

MAR 22 1946 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1946 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25-1946 to 3-20-1946, and that I last saw h alive on 3/20 1946

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Thrombophlebitis, femoral v. —

Due to —

Other Conditions: H C V D, Fracture of femur (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence February 25 at 8 P. M.
(c) Where did injury occur? 1733 Cliftview Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell.

23. Signature [illegible]

Address Sinai Hospital Date signed 3/21/46

VS 150

App. By — Benedict Stutzbic M.D. X med Ex

G38601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G38601 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Sts
(c) Hospital or institution:
West Balto. Gen. Hop. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Rapp

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-8038

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lula Rapp.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22nd 1883

8. AGE: Years 62 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation Boiler Machanist

11. Industry or business B & O R.R.

FATHER
12. Name Henry Rapp.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Lehter.
15. Birthplace Balto Md.

16 (a) Informant Lula E. Rapp
(b) Address 1110 W. Lombard St

17 (a) Burial (b) Date thereof 3/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto - Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

MAR 22 1946
(Date rec'd by registrar) (b) Huntington Wm. Deputy, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21-46 1946 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1946, to 3-21 1946, and that I last saw h alive on 3-21 1946.

Immediate cause of death Resp. ✓
Cardiac failure

Due to Myocardial degeneration

Due to possible coronary insufficiency

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert C. Herrmann M. D.
Address 285 Ashland ave Date signed 3-21-46

VS 150

G38603 G38603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 N Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Power

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Sonya Power
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 29th 1898

8. AGE: Years	Months	Days	If less than one day
47	11	22	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George A. Power
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Alice Lisle
15. Birthplace Balto. Md

16 (a) Informant Kenneth L. Power
(b) Address 1003 N. Stricker St.

17 (a) Burial (b) Date thereof 3/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAR 22 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946 at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Emphysema, Marked C. Chronic Bronchitis; Asthma.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fratarcangeli M.D.
Medical Examiner.
Date signed 3-21-46

G38603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G38603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4152 Similco Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Dubb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Yehuda
13. Birthplace Russia

MOTHER
14. Maiden Name Lipsky
15. Birthplace Russia

16 (a) Informant Michael Dubb
(b) Address 420 N. Patterson Pk. Ave

17 (a) Buried (b) Date thereof 3-22-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Child Welfare Cem.
Location Wash. Blvd

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Balto. St

MAR 22 1946
(Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21- 1946 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1946 to 3-21 1946, and that I last saw him alive on 3-21 1946

Immediate cause of death: Carcinoma of Stomach & prostate metastases

Due to: to chest

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Pat M. D.
Address Sinai Hosp Date signed 3-21-46

VS 150

G38604
488526

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G38604
CERTIFICATE OF DEATH 52a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Staten Island (If outside city or town limits, write RURAL and give town)
(d) Street No. Morgan Hills (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kintzing P. Emmons.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-72

8. AGE: Years 73 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Barber.

11. Industry or business

FATHER 12. Name Frank T. Emmons
13. Birthplace Mass.

MOTHER 14. Maiden Name Mary W. Burke
15. Birthplace Mass

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-46 (month) (day) (year)
(c) Cemetery or crematory Moravian Cem
Location Staten Island, New York

18 (a) Funeral director Leonard J. Ryck
(b) Address 5265 Hylan Blvd

19 (a) MAR 22 1946 (Registrar's date stamp) (b) Huntington W. Virginia

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 21 1946 at 5.41 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1946 to March 21 1946 and that I last saw him alive on March 21 1946

Immediate cause of death: Hypernephroma

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice R. Winstead M.D.
Address 2417 Date signed 3/22/46

VS 150

X

PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The ...s especially important. Physicians: please write the causes of death clearly and legibly.

Fr. Franklin
11 G38605 St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 ✓ G38605 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 Kenwick Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Kenwick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John T. Justice.

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widower.
6 (b) Name of husband or wife: Annie L. Justice
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) May 19, 1872
8. AGE: Years 73 | Months 10 | Days 2 | If less than one day hr. min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name James L. Justice.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary A. Freed.
15. Birthplace Maryland.

16 (a) Informant James Justice.
(b) Address 2917 Kenwick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 25/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampstead

18 (a) Funeral director Townsend & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date received by Registrar) (b) MAR 27 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1945 to March 21 1946 and that I last saw him alive on March 19 1945.

Immediate cause of death	Duration
Coronary Failure	
Due to Arterial Sclerosis	
Due to Hypertension	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 123 St Paul St Date signed Mar 25 1946

Huntington Williams, M.D.

VS 150

638606 — BALTIMORE CITY HEALTH DEPARTMENT — 638906 Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3608 Ash St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 Ash St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. Brother.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married.

6 (b) Name of husband or wife Earl Brother
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1890

8. AGE: Years	Months	Days	If less than one day
56	1	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theobald M. Donaldson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary A. Dunn.
15. Birthplace Maryland.

16 (a) Informant Earl Brother
(b) Address 3608 Ash St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location Balto Co. Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date received by registrar) (b) Registrar

MAR 22 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1946 at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Mar 20 1946 and that I last saw h[er] alive on May 19 1945

Immediate cause of death	Duration
Congestive Heart Failure	3-4 days
Due to Hypertensive H-V.	
Due to Hypertensive Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. H. Harman M.D.
Address 4037 Fulton Ave. Date signed 3/24/46

X

G38607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G38607

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 St Paul St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 12 52
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 St Paul
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Dr. William Moser Fouch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Elizabeth H. Fouch

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 23 1859

8. AGE: Years 86 | Months 9 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Fayette Co. Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Pharmacist

FATHER 12. Name John A. Fouch
13. Birthplace Penna

MOTHER 14. Maiden Name Sarah Moser
15. Birthplace Penna

16 (a) Informant Mrs C. H. Pabisik (daughter)
(b) Address 3004 St Paul St

17 (a) Burial (b) Date thereof 3-22-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Stewart Mowen Co.
(b) Address 108 W Mt Vernon Pl

19 (a) MAR 22 1946 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1946 to Mar 19 1946 and that I last saw him alive on Mar 19 1946

Immediate cause of death	Duration
Generalized Arteriosclerosis	Indefinite
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 727 N. Charles Date signed Mar 20-46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 W. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH C. HOOD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Robert E. L. Hood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	17	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Veise
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Catherine A. Ferguson
15. Birthplace Balto. Co., Md.

16 (a) Informant Rev. Nelson F. Veise
(b) Address 408 Reisterstown Rd., Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

MAR 22 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1946, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1946 3/21 1946 and that I last saw [illegible] alive on 3/21/1946.

Immediate cause of death	Duration
Coronary thrombosis	4 days
Due to Arteriosclerosis -	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature] M. D.
Address 1906 W. Balto St. Date signed 3/22/46

X

Poe G38609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G38609 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Thomas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH WAYNE POE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1941

8. AGE: Years	Months	Days	If less than one day
4	11	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph E. Poe
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Goldie Doris Martin
15. Birthplace Balto., Md.

16 (a) Informant Mr. Joseph E. Poe
(b) Address 1812 Thomas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1946 to 3/21 1946, and that I last saw him alive on 3/21 1946.

Immediate cause of death	Duration
cerebral thrombosis	
Due to congenital heart disease	
Due to	
Other Conditions bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: cerebral thrombosis; congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Schultz M.D.
Address Sinai Hospital Date signed 3/21/46

VS 150

Huntington Williams, M.D.

G38610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38610 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Hgts ave.
(c) Hospital or institution: Alberta Nursing Home 28 +
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4611 Edmondson ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Clark, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Effie A. Fringer
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1877

8. AGE: Years	Months	Days	If less than one day
68	6	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Interior Decorator

FATHER
12. Name Adam G. Clark
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Shoemaker
15. Birthplace Md.

16 (a) Informant Mrs. Effie A. Clark
(b) Address 4611 Edmondson ave.

17 (a) Burial (b) Date thereof Mch. 22/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grace Reformed Cem.
Location Taneytown, Md

18 (a) Funeral director Harry H. Wiltse
(b) Address 4101 E. Lombard St Huntington Station, Md.

19 MAR 22 1946 (Date received by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19/46. 19 , at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945, to Mar 19 1946, and that I last saw h alive on Mar 19 1946.

Immediate cause of death	Duration
Terminal Pneumonia.	3 days.
Due to Cerebral Hemorrhage	5 weeks.
Due to Arteriosclerosis.	?.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Sumner MD
Address 3003 Edmondson Ave Date signed 3/20/46.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G38611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles McMahon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept - 1901

8. AGE: Years	Months	Days	If less than one day
44 45	6		hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Cake Salesman

11. Industry or business

FATHER 12. Name Patrick H. McMahon

13. Birthplace NY

MOTHER 14. Maiden Name Celia Greenan

15. Birthplace Baltimore

16 (a). Informant Mr H. McMahon

(b) Address 1200 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)

(c) Cemetery or crematory Catherdral

Location 4th Ave & Fremont Rd

18 (a) Funeral director J. J. Fahey & Sons

(b) Address 1318 Light St

MAR 22 1946 (Date rec'd by registrar)

(b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1946, at 1:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions Epilepsy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature F. J. Fahey M.D. Medical Examiner.
Date signed 3/21/46

VS 151

G38612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G38612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 Hollins
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 1
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Hollins (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME James Rogan Johnston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced widower.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min. (66)

9. Birthplace (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Robert G Gross
(b) Address 820 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2939 Frederick Ave

18 (a) Funeral director John Conway & Son
(b) Address 901-03 Hollins St.

19 (Date received by registrar) MAR 22 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946, at 61 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945, to Mar 21 1946, and that I last saw him alive on Mar 16 1946.

Immediate cause of death Chronic Endocarditis — Duration 5 yrs.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature W B Parsons M.D.
Address 1710 Eutaw Pl Date signed 3/24/46

VS 150

G38613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G38613 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 N. Central Avenue
(c) Hospital or institution:

9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 N. Central Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Russell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Walter T. Russell
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): October 25, 1891

8. AGE: Years: 54 | Months: 4 | Days: 26,27 | If less than one day: ###### Hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Joseph M. Hoover
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary C. Buchholz
15. Birthplace: Maryland

16 (a) Informant: Miss. Dorothy A. Russell
(b) Address: 1507 N. Central Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Avenue
18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) ____ (b) ____
(Date rec'd by Registrar) Registrar

MAR 22 1946 Huntington Maryland

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 1946 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1942 to March 20 1946, and that I last saw h[er] alive on March 20 1946

Immediate cause of death: Acute cardiac dilatation with collapse of left ventricle — Duration: 3 days

Due to: Chronic myocarditis, Acute tracheo bronchitis

Due to: Pyelonephritis

Other Conditions: Anaemia, Chr. passive congestion of lungs
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: H. V. Harbold, M. D.
Address: 4206 Harford Road Date signed: 3/22/46

G38614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G38614

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 E. Oliver St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis Milton Weedon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Cornelein Weedon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7 1893

8. AGE: Years 52 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Pipe fitter

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Elias Weedon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mollie Schmidt
15. Birthplace Baltimore

16 (a) Informant Mrs Cornelein Weedon
(b) Address 1631 E Oliver St.

17 (a) Burial (b) Date thereof 3-23-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem—
Location E North Ave

18 (a) Funeral director Kendall E Humphreys
(b) Address 6067 Harford Rd

19 (a) MAR 22 1946 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 1946 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1945 to 3/20 1946 and that I last saw him alive on 3/20 1946

Immediate cause of death	Duration
Adenocarcinoma of Rt Lung	1 yr
Due to Myocardial degeneration	2 weeks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-5-45

Major findings of operation: Adeno Carcinoma

of autopsy: Rt Lung Ca

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work?
(Specify type of place)
(e) Means of injury No

23. Signature Daniel Miller M. D.

Address 1500 N Broadway Date signed 3/21/46

G38615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G38615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Key Highway
(c) Hospital or institution: Emergency Hospital Bethlehem Steel Co.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Milke

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-4732

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife May Milke

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 4th 1898

8. AGE: Years	Months	Days	If less than one day
47 48	8	16	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Boiler Maker

11. Industry or business Beth. Steel Co.

FATHER
12. Name August Milke
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant May Milke
(b) Address 1704 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25th (month) (day) (year) 1946

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave

(a) Date received MAR 22 1946 (b) Registrar's signature Hampton Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1946 at 8:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gotham M.D.
Medical Examiner.
Date signed March 21 1946.

G38616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c ✓

G38616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2441 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2441 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie L. Nowell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Lemuel Nowell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1867

8. AGE: Years 78 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House - wife

11. Industry or business

FATHER 12. Name William Warner.

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Mary Canapp

15. Birthplace Harford County, Md

16 (a) Informant Mrs. Warner.

(b) Address 2441 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25 1946 (month) (day) (year)

(c) Cemetery or crematory Woodlawn.

Location Baltimore, Md

18 (a) Funeral director Durward D. Arington

(b) Address 21 W. 25th St.

19 (a) (Date rec'd by registrar) MAR 22 1946 (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946, to May 21 1946 and that I last saw h[er] alive on May 20 19 46.

Immediate cause of death: Cardiac insufficiency — Duration: 48 hours

Due to: Senile degeneration — Duration: Several years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roscoe H. Hoover M. D.

Address 2438 Maryland Ave Date signed 3-22-46

X

G38617 BALTIMORE CITY HEALTH DEPARTMENT G38617
Registered No.

CERTIFICATE OF DEATH 46 H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Beechler Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Gregory Athens
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 1916

8. AGE: Years	Months	Days	If less than one day
29	8	20	hr. min.

9. Birthplace Idaho (Town, county, and state)
10. Usual Occupation Restaurant Proprietor
11. Industry or business

FATHER 12. Name Jus
13. Birthplace Greece

MOTHER 14. Maiden Name Georgopoulos
15. Birthplace Idaho

16 (a) Informant Peter Athens
(b) Address 3730 Beechler Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Cem.
Location Baltimore Md
18 (a) Funeral director Durward L. Covington
(b) Address 21 W. 25th St.
19 (a) MAR 22 1946 (Date received by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/46 19 at 4:56 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1945 to 3/20 1946 and that I last saw him alive on 3/20 1946.

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation 12/19/45
Major findings of operation: Carcinoma of colon
of autopsy: not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Fr. Norton Kratz
Address St Agnes Hosp. Date signed 3/20/46 M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38618 | BALTIMORE CITY HEALTH DEPARTMENT | G38618

CERTIFICATE OF DEATH 1248

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Epps

3 (b) If veteran, name war: W.W. I

3 (c) Social Security Account No. 218-10-3576

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th 1900

8. AGE: Years	Months	Days	If less than one day
45	11	11	hr. min.

9. Birthplace Greenville, Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Fred Epps
13. Birthplace Va.

MOTHER
14. Maiden Name Hannah Epps
15. Birthplace Va.

16 (a) Informant: Cora Hicks
(b) Address 100 Railroad St Emporia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-1946 (month) (day) (year)
(c) Cemetery or crematory Masdonia Cem.
Location Greenville Co, Va.

18 (a) Funeral director Belfont Hyamjo & Wright
(b) Address 721 Aliceanna St

19 (a) (Date rec'd by State Registrar) MAR 22 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-1946 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Esophageal varices
Due to Portal Cirrhosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Benedict Abramson M.D.
Date signed 3-18-46 Medical Examiner.

G38619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G38619 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 536 S. Bethel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Hammill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School

18 (a) Funeral director
(b) Address

MAR 22 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1946, at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stutarlle M.D. Medical Examiner.
Date signed 3-13-46

MAR 22 1946 Commissioner of Health

VS 151

3376

X

G38620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G38620

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq Hosp. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 W. Balto St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Drake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Loc. Johns Hopkins Medical School MAR 22 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 22 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

F 3377

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946, at 5.30 A.M.

21. I certify that I took charge of the remains described above, held an Onsp Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.
Date signed March 9, 1946.

X

G38621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G38621 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3802 Cranston ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Cranston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ce Cilia M. Kuhl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late Andrew A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1865

8. AGE: Years 81 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Francis Wissel
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Elizabeth Linnbaums
15. Birthplace Germany

16 (a) Informant Mrs. Beatrice R. Lenhart
(b) Address 3802 Cranston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road.

18 (a) Funeral director Harry H. Kuhfuss
(b) Address 4101 E. Monument ave

19 (a) 1946 (Date received by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/46. 19 , at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1945 to MARCH 20, 1946, and that I last saw h[illegible] alive on FEB 26, 1946.

Immediate cause of death: CORONARY OCCLUSION — Duration: 10 Min.
Due to:
Due to:
Other Conditions: Arteriosclerosis & Arteriosclerotic Heart Disease — 6+ years
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edgar H. Mueller
Address 2623 Woodbourne Ave Date signed 3/23/46 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R 22

VS 150

G38622 ✓ G38622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 Maunde Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Maunde Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Wilder

3 (b) If veteran, name war: Ans

3 (c) Social Security Account No. 215-09-1828

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret M. Wilder

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) June 19 1885

8. AGE: Years 60 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Factory Work

11. Industry or business Plumber Tel Fitter Quartz

FATHER
12. Name John D. Wilder
13. Birthplace Philadelphia Quartz

MOTHER
14. Maiden Name Emma Keyser
15. Birthplace Balto Md

16 (a) Informant Margaret M. Wilder
(b) Address 512 Maunde Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25 1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director C. Bernard Evans
(b) Address 1402 Pennsylvania Ave

19 (a) 3-22-46 (Date received by registrar) (b) Huntingtown Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1942 to March 20 1946, and that I last saw h[illegible] alive on March 16 1946

Immediate cause of death: Pulmonary Edema

	Duration
Due to Cardiac Decompensation	1944
Due to Arterio-Sclerotic Cardio Vascular - Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 324 Cathedral St (Date signed) M. D. 3/21/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

Registered No. G38623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Joplin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Welsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Frederick Howard Welsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1923

8. AGE: Years	Months	Days	If less than one day
22	6	2	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housf.
11. Industry or business

FATHER
12. Name Rudolph Riterour
13. Birthplace Va.

MOTHER
14. Maiden Name Oma Hamm
15. Birthplace Va.

16 (a) Informant Frederick H. Welsh
(b) Address 1205 Joplin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Edw. C. Miller Son
(b) Address 243 E Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 22 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21- 1946, at 1 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1946, to 3-21 1946, and that I last saw her alive on 3-21 1946

Immediate cause of death	Duration
Cardio-Resp. Failure -	
Due to Diffused Peritonitis	
Due to Ruptured Appendix	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Stratton M.D.
Address Mercy Hosp Date signed 3-21-46

G38624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G38624 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 S. Newkirk Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 837 S. Newkirk Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH FIEDLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Gertrude Fiedler
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 23, 1879

8. AGE: Years	Months	Days	If less than one day
66	10 11	28 27	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business U.S. Coast Guard

FATHER
12. Name George Fiedler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Gertrude Fiedler - widow
(b) Address 837 S. Newkirk Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) 3-22-1946 (Date filed by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH March 20 1946 at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1946 to 3/20 1946 and that I last saw him alive on 3/20 1946.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	
Due to Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Tatnall T. Hutchinson M. D.
Address 1076 S. East Ave. Date signed 3/21/46

VS 150

G38625 G38625

CVK-29081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 12- V
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Thrasher Court (If rural give location)
(e) Citizen of foreign country? E (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Goodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8-1916

8. AGE: Years	Months	Days	If less than one day
30	1	10	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Goodman
13. Birthplace South Carolina

MOTHER
14. Maiden Name Mary ?
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-1946 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Lynchburg, S.C.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) MAR 22 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946 at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1946 to March 18 1946, and that I last saw him alive on March 18 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis with fatal Hemoptysis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert W. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 3/21/46

G38626 HENRY LINHORST WELLS, JR. ✓ G38626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Parkville
(If outside city or town limits write RURAL and give town)
(d) Street No. 3019 Hess Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Linhorst Wells - Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19-1936

8. AGE: Years	Months	Days	If less than one day
9	3	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Henry L. Wells, Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret E. Gallagher
15. Birthplace Md.

16 (a) Informant Mrs. Henry Wells, Sr.
(b) Address 3019 Hess Avenue

17 (a) Burial (b) Date thereof 3/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) MAR 22 1946 (b) Hunter for Williams M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1946 at 5:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull. Crushed Chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-21-46 at 5:05 P. M. Coll. Co.
(b) Where did injury occur Harford Rd. & Willow Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by truck.

23. Signature Benedict Skitarski M.D.
Medical Examiner.
Date signed 3-22-46

X

G38627 BALTIMORE CITY HEALTH DEPARTMENT G38627
Registered No.

CERTIFICATE OF DEATH

64

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5000 Wright ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Armistead Gardens
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Wright Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wayne Allen Grayheal

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/3/45

8. AGE: Years	Months	Days	If less than one day
	3	9	hr. min.

9. Birthplace Franklin Square Hospital Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wiley Grayheal
13. Birthplace Rising Sun Md.

MOTHER
14. Maiden Name Nellie Hathaway
15. Birthplace Conowingo Md.

16 (a) Informant Wiley Grayheal
(b) Address 6-000 E. Oliver St Baltimore

17 (a) Burial (b) Date thereof Mar 25 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West Nathanglam
Location Colora Md.

18 (a) Funeral director C.E. Tyson.
(b) Address Rising Sun Md.

MAR 22 1946 Huntington William Md.
(Date rec'd and filed) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 1946, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to hyperplasia of thymus.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stutarelli M.D.
Medical Examiner.
Date signed 3-22-46

X

G38628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. G38628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Robert St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Valeria Addie Craig

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10 1876

8. AGE: Years 69 | Months 5 | Days 10 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Gibson
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Valeria Palmer
15. Birthplace Canada

16 (a) Informant Elsie B. Monroe
(b) Address 517 Cumberland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Thos. Geo. H. Kelly
(b) Address 1631 Druid Hill Ave.

19 (a) [illegible] (b) [illegible] Md.

Filed MAR 23 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1946 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946, to 3-21 1946, and that I last saw h[illegible] alive on 3/19 1946

Immediate cause of death: Uremia Cardio-Vascular Renal — Duration 1 year

Due to Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Woodlawn Md. signed 3/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hosp-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr -
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 S. Ross St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George Martin Buettner

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-2555

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1897

8. AGE: Years	Months	Days	If less than one day
48	10	2	...hr. ...min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Street Car Conductor
11. Industry or business Baltimore Transit Co

FATHER
12. Name John G. Buettner
13. Birthplace Germany

MOTHER
14. Maiden Name Kunigunda Buenneweick
15. Birthplace Germany

16 (a) Informant Andrew Buettner
(b) Address 2922 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location German Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hillsdale Ave, Baltimore, Md.

19 (a) Received by (Registrar) (b) Entered by (Registrar)
MAR 23 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946, at 9 A - M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage
of Brain (Pons), spontaneous

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert L. Gaston M.D.
Medical Examiner.
Date signed 3-22-46

G38630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G38630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Hampnett Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DANIEL FREDERICK FISHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Sarah L. Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1867

8. AGE: Years	Months	Days	If less than one day
79	2	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Fisher
13. Birthplace Md.

MOTHER
14. Maiden Name Lucinda ?
15. Birthplace Md.

16 (a) Informant Mrs. Wm. E. McCord
(b) Address 3906 Cottage Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) MAR 23 1946 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21, 1946, at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1946 to 3/21 1946 and that I last saw h[illegible] alive on 3/21 1946

Immediate cause of death	Duration
Hypertension Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 5103 Harford Blvd signed 3/22/46

G38631 ✓ G38631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 Poplar Grove St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city limits, write RURAL and give town)
(d) Street No. 1507 Poplar Grove St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Ralph H. Rigdon

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary A. Rigdon

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1869

8. AGE: Years 76 | Months 4 | Days 7 | If less than one day: hr. min.

9. Birthplace Strett, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Benjamin Rigdon
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Priscilla Harkins
15. Birthplace Harford Co., Md.

16 (a) Informant Mr. Norman Rigdon
(b) Address 1507 Poplar Grove St.

17 (a) Burial (b) Date thereof 3/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rock Run Cem.
Location Harford Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAR 23 1946

19 (a) (b)
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 March 1946 at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Hofheimer M.D.
Medical Examiner
Date signed 22 March 46

G38632 BALTIMORE CITY HEALTH DEPARTMENT G38632
CERTIFICATE OF DEATH 13 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 W. Camden St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 W. Camden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Vernon Adams

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-14-9595

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1911

8. AGE: Years 34 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Md. Dry Dock

FATHER
12. Name George W. Adams
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ella M. Hardesty
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella M. Delker
(b) Address 136 W. Camden St.,

17 (a) Bruial (Burial, cremation, or removal) (b) Date thereof Mar. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director S. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date rec'd by reg.) (b) Huntington Williams M.D.

MAR 23 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1946, at 5.00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1946 to 3/21 1946 and that I last saw h. alive on 3/20 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	11 years
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Hardesty M.D.
Address 1301 Ampt Date signed 3/25/46

X

G38633 ✓ G38633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5105 Litchfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5105 Litchfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Elizabeth Walters

3 (b) If veteran, name war —

3 (c) Social Security Account No. M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband ~~or wife~~ Charles J. Walters
6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Feb. 17 1913

8. AGE: Years	Months	Days	If less than one day
33	1	4	hr. min.

9. Birthplace New York (town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Kaminski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Charles J. Walters
(b) Address 5105 Litchfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director C. Vernon Lippmond
(b) Address 4611 Park Heights Ave

19 (a) (Date rec'd by registrar) (b)

VS MAR 23 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21. 1946, at 1030 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 21 1946 to 3/21 1946 and that I last saw her alive on 3/21 1946.

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to Heart Failure	
Due to Mitral Lesion	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J Walters M. D.
Address 5276 Park Heights Ave Date signed 3/23/46

X

G38634 ✓ G38634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 E. Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY TAUBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frank Tauber (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1870

8. AGE: Years	Months	Days	If less than one day
75 yrs.	10	10	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Kelgartner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mary Carr (daughter)
(b) Address 523 N. Washington St.

17 (a) Burial (b) Date thereof 3/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (Signature of registrar) MAR 23 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946, at 12 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1946, to March 21 1946, and that I last saw h.im. alive on March 21 1946

Immediate cause of death Coronary Thrombosis — Duration 36 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry H. Kane M.D.
Address 2607 E. Preston Date signed 3-7-46

X

G38635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G38635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Tunbridge Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Tunbridge Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE STIEGLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Sylvester Stiegler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1874

8. AGE: Years	Months	Days	If less than one day
71 yrs.	6	5	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Janda
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Ottilie Rudolph - daughter
(b) Address 524 Tunbridge Road

17 (a) Burial (b) Date thereof 3/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane. Balto. Md.

18 (a) Funeral director Charles F. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Date received by Local Registrar MAR 28 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1946 to Mar 20 1946, and that I last saw h~~er~~ alive on Mar 20 1946.

Immediate cause of death: Carcinoma of liver — Duration 1945+

Due to

Due to

Other Conditions Metastasis to lungs and viscera — 1946
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Bishop M.D.
Address 501 Shenandoah Date signed Mar 22

G38636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G38636 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 N Highland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen L. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry A Miller

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) June 21-1895

8. AGE: Years 50 | Months 8 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER
12. Name Aug H Rullmann
13. Birthplace Baltimore

MOTHER
14. Maiden Name Fannie Colley
15. Birthplace Baltimore

16 (a) Informant Mrs Howard Williams
(b) Address 821 S Dean St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23/46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MAR 23 1946

Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1945, to March 20 1946, and that I last saw h alive on March 19 1946.

Immediate cause of death	Duration
Carcinoma of Rt Breast	
Metastatic Carcinoma of Lung	11-16
Due to Generalized Carcinomatosis	2-20-46
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed Schemmel M.D.

Address 842 E Eutaw Pl Date signed 3-22-46

X

638637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

638637 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address B'dway + Fairmount St
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dundalk
(c) City or town Dundalk - 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2246 Edgewater Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Williamson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 27 1870

8. AGE: Years	Months	Days	If less than one day
75	10	25	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Mr Sidney CANNON
13. Birthplace North Carolina

MOTHER
14. Maiden Name MARGARET FARRAL
15. Birthplace North Carolina

16 (a) Informant Mrs Eileen Marshall (daughter)
(b) Address 2246 Edgewater Ave

17 (a) REMOVAL (b) Date thereof 3-23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PAW CREEK
Location CHARLOTTE, N. CAR.

18 (a) Funeral director WILLIAM COOK, ENB.
(b) Address 1217 ST. PAUL ST.

19 (a) MAR 23 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946, at 10: P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1946, to PM March 22 1946, and that I last saw her alive on March 22 1946.

Immediate cause of death	Duration
(a) Cardiac Failure	
Due to Arteriosclerotic Cardio Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Owen D. Campbell M. D.

Address Church Home + Hosp Date signed 3-25-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38638 ✓ G38638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 498

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 N. Paca st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie Bivens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul. 1908

8. AGE: Years 37 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Blind

11. Industry or business

FATHER
12. Name Daniel Bivens
13. Birthplace Georgia

MOTHER
14. Maiden Name Josephine Bivens
15. Birthplace Georgia

16 (a) Informant Annie L. Carter
(b) Address 627 N. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 915 Druid Hill Ave

19 (a) MAR 23 1946 (Date rec'd by Registrar) (b) 1946 Huntington Wilkerson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1946 at 3P M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of the vulva with metastase to liver.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skaterlis M.D. Medical Examiner.
Signed 3-19-46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 R

Registered No. 638639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Muth

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Catharine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1834

8. AGE: Years 12 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Post office

FATHER
12. Name John G Muth
13. Birthplace Balto

MOTHER
14. Maiden Name ?
15. Birthplace Balto.

16 (a) Informant Kathrine Muth
(b) Address 1119 Forrest St.

17 (a) Burial (b) Date thereof 3-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Joseph Kaminskas
(b) Address 602 W. Lexington St.

19 (a) (Date received) MAR 23 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1946, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1946 to 3/21 1946, and that I last saw h[illegible] alive on 3/21/46 19

	Duration
Immediate cause of death Cachexia	7 days
Due to Carcinoma of stomach	2 years
Due to	
Other Conditions Arteriosclerotic Heart Disease. Peritonitis Pernicious Anemia	

(Include pregnancy within 3 months of death)

Date of operation 2/26/46
Major findings of operation Peritonitis - Abscess
of autopsy Carcinoma of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Chessin
Address Sinai Hospital Date signed 3/21/46 M. D.

Washington Williams, M.D.

G38640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G38640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 S. Woodington Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: White | 5. Color or race: Female | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23rd 1886

8. AGE: Years 59 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roland Gibson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Steavers
15. Birthplace Md

16 (a) Informant Frank M. Bradley
(b) Address 1-S. Woodington Rd

17 (a) Burial (b) Date thereof 3 25 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Long Green Md.

18 (a) Funeral director Leo G. Lewis
(b) Address 1701-03 N. Patterson Park Ave

19 (a) MAR 23 1946 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21- 1946, at 4 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions Angina Pectoris

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skiarski M.D.
Medical Examiner.
Date signed 3-22-46

X

...information asked for on this certificate, with UNFAILING ACCURACY. Every item is important. Physicians: please write the causes of death clearly and legibly.

G38641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

Registered No. G38641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 W. Conway St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 W. Conway St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Bussey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1894

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Emma Offer
(b) Address 641 W. Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery or crematory Lincoln Mem.
Location Washington D.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Druid Hill Ave.

19 (a) MAR 29 1946 (b) Huntington Mills Funeral Home, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22 1946 at 8.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1946 to Mar 22 1946 and that I last saw him alive on Mar 22 1946.

Immediate cause of death Bronchopneumonia and Malnutrition — Duration about 2 mos
Due to unknown
Note: No sign of T.B.C
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John W. Gaines M.D.
Address 506 W. Hamburg St. Date signed 3/23/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item correct age is especially important.

G38642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G38642

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Raymond B Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 3rd 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Francis B Thayer
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary F. Unknown
15. Birthplace Germany Unknown

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Avenue

18 (a) Funeral director Frederick Smeltz Inc
(b) Address 3 619 E. Monument Street

19 (a) MAR 24 1946 (b) Huntingtown Williamsport, Md.
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1946 at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1946 to Mar 22 1946 and that I last saw her alive on Mar 22 1946.

Immediate cause of death	Duration
Cerebral Vascular Accident	6 HRS
Due to ? Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Hellman M. D.
Address Johns Hopkins Hosp. Date signed 3-22

VS 150

G38643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38643

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bellona Ave + Brightside Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella May Miles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1869/86

8. AGE: Years	Months	Days	If less than one day
85	5	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation housekeeper
11. Industry or business

FATHER
12. Name Thomas Miles
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Ann Johnson
15. Birthplace Maryland

16 (a) Informant Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 25 1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address McCulloh & Orchard Sts

19 (a) MAR 24 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1946, to Mar. 22 1946, and that I last saw h[illegible] alive on Mar. 22 1946.

Immediate cause of death Coronary artery occlusion & myocardial infarction — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford V. Kirkpatrick Jr. M. D.
Address Union Memorial Hosp. Date signed 3-22-46

VS 150

G38644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G38644
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Springdale Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin M Saull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Celia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Dental Bussiness

FATHER
12. Name Kopel Saull
13. Birthplace Russia

MOTHER
14. Maiden Name Esther Fagel ?
15. Birthplace Russia

16 (a) Informant Celia Saull
(b) Address 3502 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 1946

Interring for Williams, M.D.

MEDICAL CERTIFICATION 5.10

20. DATE OF DEATH March 22 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to March 22 1946 and that I last saw h. alive on March 22 1946.

Immediate cause of death	Duration
Carcinoma of the liver	8 mths
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 1720 E Fort Ave Date signed 3/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Lyndenbaum Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8056 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Martini

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1943

8. AGE: Years	Months	Days	If less than one day
2			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation 0
11. Industry or business 0

FATHER
12. Name Melvin Martini
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Laura Nagalaski
15. Birthplace Baltimore, Md.

16 (a) Informant Melvin Martini
(b) Address 8056 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary.
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 (a) (b)
(Date rec'd by reg.) Huntington Williams, M.D. Registrar

MAR 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946, at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1946, to 3-23 1946, and that I last saw h. im alive on 3-23 1946.

Immediate cause of death	Duration
Diphtheritic Myocarditis	
Due to Diphtheria	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elizabeth Spragins M. D.
Address Lyndenbaum Hosp. Date signed 3-23-46

G38646

489640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Wundalk. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Bonnrall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Horace P. Baller

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Ron.

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 6-21-12

8. AGE: Years 33 | Months 9 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Machinist.

11. Industry or business Owens Yacht Co.

FATHER
12. Name William Baller.
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth McKinnon
15. Birthplace N. C.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/24/46 (month) (day) (year)
(c) Cemetery or crematory Drexel
Location N. C.

18 (a) Funeral director Wilkins-Cook Inc.
(b) Address 1217 St. Paul St.

1946 (b) rec'd by registrar Langston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to March 23 1946, and that I last saw him alive on March 22 1946.

Immediate cause of death: (a) Subarachnoid hemorrhage — Duration: 3 wks.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Pendergrass
Address Johns Hopkins Hosp. Date signed 3/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G38647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 838

G38647 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. ... age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Haverhill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Cole.

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	M.

6 (b) Name of husband or wife Richard A. Cole
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) about 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Henry Sadofsky
13. Birthplace Germany

MOTHER
14. Maiden Name —unknown
15. Birthplace "

16 (a) Informant William A. Cole
(b) Address 1116 Haverhill Rd.

17 (a) Burial (b) Date thereof 3/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 24 1946 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1946, at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1946 to 3-23 1946, and that I last saw her alive on 3-23 1946.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Hypertension.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. Butler. M. D.
Address University Hosp. Date signed 3-23-46

VS 150

Huntington Williams, MD

X

G38648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38648
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 136
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3665 Hickory ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Frank Painter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Susie C. Painter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15-1874

8. AGE: Years	Months	Days	If less than one day
71	5	7	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Herman St. Painter
(b) Address 2344 Baldo Street

17 (a) Burial (b) Date thereof March 26-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Marys Catholic Cemetery
(d) Location Baltimore Co. Md.

18 (a) Funeral director Rurgee Funeral Home
(b) Address 3021 Falls Road

19 (a) MAR 24 1946 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-1946, at 12 [illegible] P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 3-22-46

G38649 G38649

TN. 99612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4018 Evans Chapel Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Wiley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Oscar K. Wiley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21st 1901

8. AGE: Years	Months	Days	If less than one day
44	7	1	hr. min.

9. Birthplace Va. (town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Andrew Simons
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Beach
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25 1946 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 2631 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 24 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 1946 at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1st 1946 to Mar 22 1946 and that I last saw her alive on Mar 22 1946 A.M

Immediate cause of death Cachexia — Duration

Due to Ca of Stomach & Metastasis to Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M.D.
M. D.
Address Balt. City Hosps Date signed 3-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 | a

G38650

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Pierce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Neil McAllester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-1917

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Neil McAllester
13. Birthplace N. C.

MOTHER
14. Maiden Name Alice Jones
15. Birthplace N. C.

16 (a) Informant See mdr.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Silver [illegible]
Location Rayford N. C.

18 (a) Funeral director Chas H Alexander
(b) Address 947 N Mont St
(By) Livingston Williams Mgr.

MAR 24 1946
(Date filed) (Registrar)

MEDICAL CERTIFICATION

A

20. DATE OF DEATH March 21 1946 at 4.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1946, March 21 1946 and that I last saw him alive on March 21 1946.

Immediate cause of death: Basilar meningitis, Etiology unknown.

Due to

Due to

Other Conditions Ectop - dural hematoma, L. hemisphere, operation

(Include pregnancy within 3 months of death)

Date of operation 3/20/46

Major findings of operation: None.

of autopsy Basilar meningitis. Extradural hematoma

Duration

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature [illegible]
Address The Johns Hopkin Hosp Date signed M. 3 D. 21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

c G38651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha B. Pugh.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife John A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1876

8. AGE: Years 69 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace W. Virginia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Basil Shanholtzer

13. Birthplace Va.

MOTHER 14. Maiden Name Elizabeth Pepper

15. Birthplace Va.

16 (a) Informant Arthur Pugh

(b) Address 2106 Barclay St

17 (a) Removal (b) Date thereof 3/24/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mallick Cem.

Location Augusta, W. Va.

18 (a) Funeral director Wm Cook Inc

(b) Address 1211 St Paul st.

19 (a) Filed by (b) Registrar

MAR 27 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1946 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1946 to 3/24 1946 and that I last saw alive on 3/21 1946.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Zach. B. Morgan M.D.

Address 67 E. Eland St Date signed 3/25/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38652 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 W. 27th street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 W. 27th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET McCROSSON

3 (b) If veteran, name war ------
3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	29	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John McCrosson
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret McGarrell
15. Birthplace Ireland

16 (a) Informant Miss Nellie McCrosson
(b) Address 19 W. 27th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery or crematory St. Peter's
Location 1300 Moreland avenue

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) MAR 24 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946 at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to March 23 1946 and that I last saw her alive on March 21 1946

Immediate cause of death	Duration
Respiratory Failure	3 Days
Due to Hypostatic Pneumonia	5 Days
Due to Arteriosclerotic Cardio-Renal Disease	20 Yrs
Other Conditions Dementia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Charles F. O'Donnell M. D.
Address 2301 York Rd Date signed 3/28/46

Huntington Williams, M.D. Registrar

VS 150

G38653 G38653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 181

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Coldspring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Mt. Carmel (If outside city or town limits, write RURAL and give town)
(d) Street No. Pretty Boy Dam Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George James Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	25	— hr. — min.

9. Birthplace Parkton, Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Self

FATHER
12. Name Martin L. Lawson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ann Burns
15. Birthplace Md.

16 (a) Informant William Wilhelm
(b) Address Woodlawn, Balto. Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 25, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Mt. Carmel, Balto. Co. Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

MAR 24 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1946, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 16 1946 to MARCH 23 1946, and that I last saw him alive on MARCH 22 1946.

Immediate cause of death	Duration
GLOMERULAR NEPHRITIS	5 days.
Due to 2nd degree burns- both legs	10 days.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Acc
(b) Date of occurrence about March 5, 1946 M
(c) Where did injury occur? Mt. Carmel, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burned legs while burning brush

23. Signature Howard R. Kleeman M.D.
Address 3803 Edmondson Ave. Date signed 3/23/46

Howard R. Kleeman, M. D. 121

378916 G38654 BALTIMORE CITY HEALTH DEPARTMENT G38654
CERTIFICATE OF DEATH 153

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town St. Louis (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Westgate (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA Wrobel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry Wrobel

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 7-1-02

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Jo Erlich
13. Birthplace Poland

MOTHER 14. Maiden Name Sarah Preznicka
15. Birthplace Poland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/24/46 (month) (day) (year)
(c) Cemetery or crematory St. M.
Location St. Louis Mo.

18 (a) Funeral director Sol Levinson Bros.
(b) Address 1124-26 W. Pratt

MAR 21 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946 at 9:40 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1946 to 3-23 1946 and that I last saw her alive on 3-23- 1946.

Immediate cause of death Sclero derma, -with general visceral involvement — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Truman Riddar, jr. M. D.
Address Johns Hopkins Hosp. Date signed 3/23/46

Milton X

G38655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38655 Registered No.

HB #99958

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. Hospitals
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Neil Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1942

8. AGE: Years	Months	Days	If less than one day
3	3	18	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Reeves
13. Birthplace N. C.

MOTHER
14. Maiden Name Luella Scott
15. Birthplace N.C.

16 (a) Informant Balto. City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co.,

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna, Ave.

MAR 24 1946 Huntington Williams M.D.
(Date Rec'd) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1946, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15, 19 46 to March 22, 19 46, and that I last saw h im alive on March 22, 19 46

Immediate cause of death Miliary Tuberculosis
Tuberculous Meningitis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Approx. Hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Baylutt M. D.
Address Balt. City Hosp. Date signed 3/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G38656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √159

G38656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 N Milton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Joseph Grob.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife –

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Mar 24th 1946

8. AGE: Years | Months | Days | If less than one day hr. 2 min.

9. Birthplace Maryland Gen. Hosp.
(Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER
12. Name Christian Charles Grob.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Elizabeth Green
15. Birthplace Baltimore Md.

16 (a) Informant Christian Charles Grob.
(b) Address Baltimore Md.

17. (a) Buried (b) Date thereof 3-25-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director Harry A. Wetzler
(b) Address 460 Washington Blvd

MAR 24 1946
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death	Duration
5 month fetus lived 2 minutes	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Howe M.D.
Address Maryland Gen. Hosp. Date signed 3/24/46

X

G38657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

G38657
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Cathedral.
(c) Hospital or institution:
Univ Hos
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Berkeley
(c) City or town Martinsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca E Kilgore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1938

8. AGE: Years 7 | Months 9 8 | Days 24 | If less than one day 3 hr. min.

9. Birthplace W Va.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Virgil R Kilgore.
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Ramey
15. Birthplace W Va.

16 (a) Informant Virgil R Kilgore.
(b) Address Martinsburg W Va

17 (a) Burial (b) Date thereof 3-28-46.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Tuscarora
Location Martinsburg W Va

18 (a) Funeral director J.C. Wright Undertaker
(b) Address Ellicott City Md.

19 (a) MAR 26 1946 Registrar's signature for William M. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1946, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1946, to 3/25 1946 and that I last saw h[illegible] alive on 3/25 1946

Immediate cause of death Post operative Respiratory paralysis — Duration

Due to Astrocytoma - R cerebellar hemisphere

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3/25/46
Major findings of operation: Rt. cerebellar astrocytoma encroaching on medulla
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H Skinner M. D.
Address University Hosp. Date signed 3-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The fact ago is especially important. Physicians: please write the causes of death clearly and legibly.

G38658 -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G38658

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 253 Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angelo Di Meo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Carmella
(c) If alive, give age 188 years

7. Birth date of deceased (mo., day, yr.) 12-5-~~1878~~ 1882

8. AGE: Years	Months	Days	If less than one day
64	3	18	hr. min.

Birthplace Italy
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Michael DiMeo
13. Birthplace Italy

MOTHER
14. Maiden Name Carmella Martina
15. Birthplace Italy

16 (a) Informant Carmella Di Meo
(b) Address 253 Central Ave

17 (a) Burial (Burial, Cremation, or Removal) (b) Date thereof 3/26/1946 (month) (day) (year)
(c) Cemetery or crematory

18 (a) Funeral director Randall & Lloyd
(b) Address 312 S. Broadway

MAR 25 1946
(Date filed by registrar)

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23- 1946 at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-23-46 3:45 P.M.
(b) Where did injury occur? 538 Central Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work No
(d) Means of injury Fell from roof

23. Signature Benedict Winternitz M.D.
Medical Examiner.
Date signed 3-24-46

(over)

G38659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38659 Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 S. Lehigh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S. Lehigh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jno. Brickman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 100-05-0157

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Anna Brakeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1852

8. AGE: Years 94 | Months | Days | If less than one day hr. min.

9. Birthplace Astoria (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Brickman

13. Birthplace Austria

MOTHER 14. Maiden Name Mulgrave

15. Birthplace Astoria

16 (a) Informant Eugene Brakeman

(b) Address 516 Cathedral St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-1946 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.

Location Guttenberg, New Jersey

18 (a) Funeral director Wendell Hopper

(b) Address 312 N. Howard St.

19 (a) (Date) (b) Registrar

MAR 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1946 to 3/24 1946 and that I last saw h alive on 3/22 1946

Immediate cause of death: Chronic Myocarditis Failure

Due to Senility & Gen. Art. sclerosis

Due to Lobular pneumonia ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Greenberg

Address 161 3 Eastern Ave. Date signed 3/27/46

G38660

489289.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1920

G38660

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Caroline
(c) City or town Federalsburg.
(If outside city or town limits, write RURAL and give town)
(d) Street No. River Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Velma Gannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-28.

8. AGE: Years 17. | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry Gannon
13. Birthplace Md.

MOTHER 14. Maiden Name Martha Jane Dixon
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 26 46 (month) (day) (year)
(c) Cemetery or crematory Federalsburg
Location Federalsburg Md.

18 (a) Funeral director J. Frampton Son
(b) Address Federalsburg md

19 6048 (b) (Signature of registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 23 1946, at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1946 to March 23 1946 and that I last saw him alive on March 23 1946.

Immediate cause of death	Duration
Streptococcic Bacterial Endocarditis	6 mos.
Due to Depression Workers	
Due to Rheumatic Heart Dis Mitral Stenosis & Insuff.	10 yrs.
Other conditions Cardiac Failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Hopkins

Address Johns Hopkins Hosp Date signed 3-26-46

VS 150

Huntington Williams, M.D.

G38661 BALTIMORE CITY HEALTH DEPARTMENT G38661

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County N. York
(c) City or town ~~Baltimore~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. Arundel Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. ~~Callahan~~ Callanan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/28/89

8. AGE: Years	Months	Days	If less than one day
56	7	25	hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business

FATHER	12. Name William H.
	13. Birthplace New York City
MOTHER	14. Maiden Name Anne Battle
	15. Birthplace New York City

16 (a) Informant Campbell Funeral Home
(b) Address New York City

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/24/46 (month) (day) (year)

(c) Cemetery or crematory Calvary
Location New York City

18 (a) Funeral director Wm. J. Tickler & Sons
(b) Address North & Pa. Aves.

19 (a) MAR 25 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 194

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23- 1946, at 2 20 M

21. I certify that I took charge of the remains described above, held an Autopsy + Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 3-24-46

G38662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G38662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 S. Eutaw St.
(c) Hospital or institution Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Peck St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph L. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Emma L. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-1882

8. AGE: Years 64 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual Occupation Stock keeper

11. Industry or business

FATHER
12. Name George L. Smith
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Adelaide Hartshorne
15. Birthplace Pa

16 (a) Informant Emma L. Smith
(b) Address Philadelphia Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/46 (month) (day) (year)
(c) Cemetery or crematory Fernwood Pa
Location Delaware Co Pa

18 (a) Funeral director Thilhower Coyle Inc
(b) Address 1217 St Paul St

19 (a) (b) Signature of registrar

MAR 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-46 19.., at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1946, to 3-24 1946, and that I last saw him alive on 3-23 1946.

Immediate cause of death	Duration
Cardiac Myocarditis	
Due to Coronary Thrombosis	
Due to C.V. (Arteriosclerotic) disease	
Other Conditions Lobar pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kenneth Weinberg M.D.
M.D.

Address 2806 Date signed 3-25-46

937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TN. G38663 100024 — G38663 Registered No. — 132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21st 1880

8. AGE: Years 65 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Butler
13. Birthplace Maryland

MOTHER — 14. Maiden Name Eliza
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-46 (month) (day) (year)
(c) Cemetery or crematory St Peters cem
Location George B. Kelson

18 (a) Funeral director md
(b) Address 1303 Freestman St

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 1946 19 ..., at 12.35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19th 19 46 to Mar 22 19 46 and that I last saw him alive on Mar 22 19 46

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 3-27-46

G38664 — BALTIMORE CITY HEALTH DEPARTMENT — G38664 Registered No.

CERTIFICATE OF DEATH V61

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 N. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Park ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Stolte

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Louis Stolte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24 1875

8. AGE: Years 71 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name August Knaup
13. Birthplace Germany

MOTHER
14. Maiden Name Meurer
15. Birthplace Germany

16 (a) Informant Mrs Robt Fritsch
(b) Address 1315 Patapsco St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location City

18 (a) Funeral director Lilienthal Funeral Home
(b) Address 2008 Orleans St

19 (a) Date received by registrar MAR 25 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946, at 1.2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1946 to March 23 1946, and that I last saw her alive on March 22 1946.

	Duration
Immediate cause of death: CORONARY THROMBOSIS	- 1 hr.
Due to: CARDIO-VASCULAR DISEASE	- 2 yrs.
Due to: DIABETES MELLITUS -	7 -
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Kleiman M. D.
Address 3803 EDMONDSON Date signed 3/23/46

VS 150

G38665

G38665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 W. Ostend St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 W. Ostend
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F. Foho

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary J. Foho

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14. 1876

8. AGE: Years 69 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Upholstering

11. Industry or business Furniture

FATHER
12. Name George J. Foho
13. Birthplace N. J.

MOTHER
14. Maiden Name Sophie Heubeisen
15. Birthplace N. J.

16. (a) Informant Hazel E. Myers.
(b) Address 1117 W. Ostend St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26. 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) (Date received by registrar) Huntington Williams, M.D.

MAR 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 1946, at 3 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5/45 19 to 3/23/46 19, and that I last saw h[illegible] alive on 3/22/ 1946

Immediate cause of death: Coronary thrombosis — Duration: Immediate.

Due to:

Due to:

Other Conditions: Hypertensive cardio vascular disease. — Duration: 10 mos.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hazel E. Myers M. D.

Address 1226 Hanover St. Date signed 3/23/46

X

G38666 BALTIMORE CITY HEALTH DEPARTMENT G38666
CERTIFICATE OF DEATH 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. V-B
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS A. RODGERS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: SUSIE RODGERS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 30 1868

8. AGE: Years 77 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace A.A.CO MD. (Town, county, and state)

10. Usual Occupation OYSTERMAN

11. Industry or business

FATHER
12. Name WILLIAM RODGERS
13. Birthplace MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace MD.

16 (a) Informant LILLIAN MILLS (DAUGHTER)
(b) Address 1911 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 25/46 (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location WEST RIVER MD.
(a) Name of director Leikhzeiler Inc.
(b) Address 403 S. WOLFE ST.

MAR 25 1946

19 (Filed by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1946, at 8 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1946 to 3/22 1946. and that I last saw h[illegible] alive on 3/22 1946

Immediate cause of death: Cardio Respiratory failure — Duration:
Due to: Cachexia
Due to: Carcinoma Stomach
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 3/16/46
Major findings of operation: Carcinoma stomach with perforation
of autopsy: obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Heyman M.D.
Address Md. General Hosp. Date signed 3/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Street address is especially important. Physicians: please write the causes of death clearly and legibly.

G38667 G38667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Md. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4717 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Miss Marguerite E. Heltzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1919

8. AGE: Years: 26 | Months: 10 | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Walter C. Heltzel
13. Birthplace Md.

MOTHER
14. Maiden Name Anna K. Stevenson
15. Birthplace N. Y.

16 (a) Informant Mr. Walter C. Heltzel
(b) Address 4717 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery or crematory Mouland Park
Location Rayon Ave

18 (a) Funeral director Leonard J. Rucke
(b) Address 5305 Harford Road

19 (a) MAR 25 1946 (b) (Filed by registrar) Registrar's

Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1946 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1946 to 3/22 1946 and that I last saw h[illegible] alive on 3/22 1946

Immediate cause of death: Malnutrition & Cachexia — Duration: 2 days
Due to: Anemia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Phillips M.D.
Address Md. Gen'l. Hosp. Date signed 3/22/46

G38668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G38668
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5100 Arabia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Mt Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Arabia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Wh.

6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: Premature | Months | Days | If less than one day: 4 hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Donald J. Butler
13. Birthplace Altoona Pa

MOTHER
14. Maiden Name Phyllis Mae Stambaugh
15. Birthplace Altoona Pa

16 (a) Informant Donald J. Butler
(b) Address 5100 Arabia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/46 (month) (day) (year)
(c) Cemetery or crematory Rosehill Cem. Altoona Pa.
Location Altoona Pa.

18 (a) Funeral director Leonard J. Rinehart
(b) Address 5205 Harford Road

MAR 25 1946
(Date rec'd by registrar)

(b) Huntington Williams Md
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1946 to March 24 1946 and that I last saw her alive on March 24 1946.

Immediate cause of death: Congenital atelectasis — Duration: 4 hours.

Due to: Premature

Due to: Underdeveloped respiratory center

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold
Address 4706 Harford Road Date signed 3/26/46

VS 150

G38669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1250

G38669 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 1/3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town O'Donnell Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Ballard Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ann Karl

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/3/44

8. AGE: Years 1 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Henry Karl
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dora Katherine Thayer
15. Birthplace Baltimore Md

16 (a) Informant Mrs Joseph Karl
(b) Address 1301 Ballard Way

17 (a) burial (b) Date thereof 3 (month) 25 (day) 1946 (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Holy Redeemer
Location Ballard Rd.

18 (a) Funeral director M. M. E. Oppenheimer
(b) Address Lombard & Moore Sts.

19 (a) (b) Clayton Williams M.D.
(Date received by registrar) Registrar

MAR 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1946, to 3/21 1946, and that I last saw h[illegible] alive on 3/21 1946.

Immediate cause of death: Cardio respiratory failure — Duration
Due to: Cerebral hemorrhage
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Hypertonic gall
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J Lyle Jr
Address St Josephs Hosp Date signed 3/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38670 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Reistertown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Bergerson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Robert Diamond
13. Birthplace Russia

MOTHER
14. Maiden Name Tillie Goldman
15. Birthplace Russia

16 (a) Informant Alvin Bergerson
(b) Address 4005 Reistertown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E Balto St
19 (a) Filed by registrar (b) Registrar Huntington Williams M.D.

MAR 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 March 19 46, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 March 19 46 to 24 March 19 46 and that I last saw her alive on 24 Mar 19 46

Immediate cause of death	Duration
Circulatory Failure	
Due to Congestive Failure	
Due to Coronary Occlusion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester A. Dees Jr. M. D.
Address West Balto Gen Hosp Date signed 3/24/46

G38671 ✓ G38671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 155

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3320 E CALVERT
(b) Street address ~~3001 GARRISON BLVD.~~
(c) Hospital or institution:
UNION MEMORIAL HOSP. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 GARRISON BLVD
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. HELEN GINSBERG

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife SOLOMON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 21, 1867

8. AGE: Years	Months	Days	If less than one day
78	5	1	hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name GUY SOHLE
13. Birthplace RUSSIA.

MOTHER
14. Maiden Name HELEN SOHLE
15. Birthplace RUSSIA

16 (a) Informant MISS EVELYN WELLS
(b) Address 818 E. PRESTON ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location East Baltimore St

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

MAR 25 1946 (Date received by registrar) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 MAR 1946 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 MAR 1946 to 22 MAR 1946 and that I last saw her alive on 22 MAR 1946

Immediate cause of death OCCLUSION OF CORONARY THROMBOSIS — Duration 20 Min

Due to ARTERIO SCLEROSIS — Duration unknown

Due to OLD AGE

Other Conditions OSTEOTOMY, RT FEMUR.
(Include pregnancy within 3 months of death)

Date of operation 13 MAR 46

Major findings of operation: ASEPTIC NECROSIS NECK OF FEMUR

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ludwig J. Pontell M. D.
Address UNION MEM. HOSP. Date signed 3/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G38672 | BALTIMORE CITY HEALTH DEPARTMENT | V G38672
CERTIFICATE OF DEATH 937 | Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring & Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam WEINER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Dena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Edmund Levin
(b) Address 1901 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location Lernan Hill Rd.

18 (a) Funeral director Jack Long Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1938 to 3-23 1946 and that I last saw him alive on 3-23 1946.

Immediate cause of death	Duration
Chr. endocar. disease	
Due to	
Due to	
Other Conditions	—

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin M.D.
Address Levindale Date signed 3/23/46

G38673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38673 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 E. Oliver Street
(c) Hospital or institution: 81
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 E. Oliver Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES ELIZABETH HARTMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Richard Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1863

8. AGE: Years	Months	Days	If less than one day
82	2	28	hr. min.

9. Birthplace Annapolis, Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Tydings
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Martha Thomas
15. Birthplace Annapolis, Md.

16 (a) Informant Mr. Albert M. Tydings
(b) Address 803 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/43 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

MAR 25 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1946 at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to March 22 1946 and that I last saw h[illegible] alive on 3/2 1946

Immediate cause of death Laceration Hemorrhage — Duration
Due to Coma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alf L Lage
Address 709 N Broadway Date signed 3/23/46 M.D.

VS 150

3 G38674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

G38674 Registered No.

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Ev... corr... age is especially important. Physicians: please write...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wickens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Strickland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia E. Moerlinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband of ~~wife~~ late Edward T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1891

8. AGE: Years 54 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Wm. Fleischer
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Brandau
15. Birthplace Md

16 (a) Informant Mrs. Chas. G. Rimbach
(b) Address 3215 Strickland St.

17 (a) Burial (b) Date thereof 3/25/46.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Tuttle
25 1946 4101 Edmondson Ave.
(Date rec'd by registrar) (Town) Registrar

19 (a)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946, at 11:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 21, 1946 M.
(b) Where did injury occur? 3215 Strickland St
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury Asphyxiation due to carbon monoxide

23. Signature Robert La Fontaine M.D.
Medical Examiner.
Date signed 3-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38675 | BALTIMORE CITY HEALTH DEPARTMENT | G38675 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2017 Hollins St
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2017 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cornelius

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Delia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1875

8. AGE: Years	Months	Days	If less than one day
70	7	15	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Baltimore Fire Dept

FATHER
12. Name Thomas Cornelius
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Dormley
15. Birthplace Ireland

16 (a) Informant Mrs Delia Cornelius
(b) Address 2017 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John Cowan & Son
(b) Address 901-03 Hollins St

19 (a) (Date received by registrar) Registrar

MAR 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1946, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1946, to 3/23 1946, and that I last saw him alive on 3/20 1946

Immediate cause of death: Coronary Disease — Duration 1 hr

Due to:

Due to:

Other Conditions Arteriosclerotic C.V. disease — 2 yrs
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. P. Fabrizzi M. D.
Address 5217 Harford Rd Date signed 3/23/46

X

G38678

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38678 Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1334, Mulberry St
(c) Hospital or institution: —
4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town N
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 E. Mulberry St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Duckett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Eugene T. Duckett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Abraham Lema
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Krantz
15. Birthplace Balto, Md

16 (a) Informant Eugene T. Duckett
(b) Address Pikesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Mrs. Frances H. Hendry
(b) Address 578 W. Biddle St.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

MAR 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/46 19 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25/46 to 3/24/46 19, and that I last saw alive on 3/21/46 19.

	Duration
Immediate cause of death Pneumonia	
Due to High Blood Pressure	7 Days
Due to Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Ellis M. D.
Address 924 Mad Ave Date signed 3/24/46

G38677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G38677 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline + Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 E. 23rd. St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** Elizabeth E. Byrne.

3 (b) If veteran, name war ---------
3 (c) Social Security Account No. ------

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/72

8. AGE: Years 74 | Months 9 | Days 21 | If less than one day hr. --- min.

9. Birthplace New Balto., Sunerset Co. Pa. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business ------

FATHER
12. Name John Byrne
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Ann Bogan
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Manaher
(b) Address 5718 Walnut St., Pittsburg Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto., Md.

18 (a) Funeral director H. W. Measelson
(b) Address 805 N. Calvert St.

MAR 25 1946 (Date received by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1946 to 3/23 1946 and that I last saw h[illegible] alive on 3/23 1946

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to Portal Cirrhosis
Pancreatic Cysts.

Other Conditions Fibroma of Uterus
Diverticulosis of Sigmoid
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Signed
of autopsy: Same as Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 3/23/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G38678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

G38678 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.,
(c) Hospital or institution:
Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5223 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Matilda Hudson

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John W. Hudson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1872

8. AGE: Years 73 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Bridgeport, Pa.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Lorenzo B. Gough
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Dill
15. Birthplace Delaware

16 (a) Informant Miss Rosa L. Gough
(b) Address 5223 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) Date received by registrar MAR 25 1946 (b) Registrar Lustington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1946 to 3/23 1946 and that I last saw her alive on 3/20 1946

Immediate cause of death	Duration
Bronchopneumonia	1 Week
Due to Transverse Myelitis ?	18 mos ?
Cord Tumor ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Karl Showman M.D.

Address 1212 N. Patterson Park Ave Date signed 3/25/46

X

G38679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G38679 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Winston Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Winston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES V. ROBINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Edwin H. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1870

8. AGE: Years	Months	Days	If less than one day
75	5	20	hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. H. Baldwin
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Carr
15. Birthplace Unknown

16 (a) Informant Mrs. Mabel Tischinger
(b) Address 421 Winston Ave.

17 (a) Burial (b) Date thereof 3/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Govans, Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 25 1946 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1946, at 4:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20 1946 to Mar 23 1946, and that I last saw her alive on Mar 22 1946.

Immediate cause of death	Duration
Broncho pneumonia	3 days
Due to Endocarditis	10 yr.
Due to Hypertension	10 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl F. Benson, M.D.
Address 5111 York Rd Date signed 3/23/46

VS 150

G38680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

Clone G38630

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Bateman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Ellen Clowe

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Jan -20- 1888

8. AGE: Years 58 | Months 2 | Days 3 | If less than one day: hr. min.

9. Birthplace Va. (Loudon Co.)
(Town, county, and state)

10. Usual Occupation Clerk - War Dept.

11. Industry or business U. S. Government

FATHER
12. Name William H. Clowe
13. Birthplace Va (Loudon Co.)

MOTHER
14. Maiden Name Agnes May Darby
15. Birthplace Md (Montgomery

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery or crematory Union Cemetery
Location Leesburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 25 1946 (Date rec'd by registrar) (b) Lington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946, at 2 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1946 to Mar 23 1946 and that I last saw h[illegible] alive on Mar 23 1946.

Immediate cause of death	Duration
Metastatic carcinoma to Brain.	
Due to Carcinoma of kidney left.	
Due to	
Other Conditions Metastases to liver, adrenals & lungs	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

Autopsy? See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence [illegible] P.M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Hopkins Hospital Date signed 3-27-46

VS 150

G38681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G38681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Inglewood Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Albert F. Paul

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1878

8. AGE: Years	Months	Days	If less than one day
68	2	26	— hr. — min.

9. Birthplace Maryland (Balto.)
(town, county, and state)
10. Usual Occupation Ship Broker
11. Industry or business —

FATHER
12. Name Charles C. Paul
13. Birthplace Maryland (St. Marys Co.

MOTHER
14. Maiden Name Mary Fotquell
15. Birthplace Maryland (St. Mary

16 (a) Informant Mrs. Sarah A. Paul
(b) Address 2822 Inglewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 25 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946 at 1:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1946 to March 24 1946 and that I last saw him alive on March 24, 1946

Immediate cause of death	Duration
Generalized peritonitis	
Due to Perforation of Cecum	
Due to Annular Carcinoma of Leptin Flexure of ascending Colon	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation March 23, 1946
Major findings of operation: Perforation Cecum, ulceration Cecum
Other operations Annular Carcinoma of Leptin Flexure of ascending Colon

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Scott Jr. M. D.
M. D.
Address Church Home & Hospital Date signed March 24, 1946

VS 150

Huntington Williams Prp

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38682

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38682

CERTIFICATE OF DEATH 939

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Mt Lucas Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA WIGHTMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1860

8. AGE: Years	Months	Days	If less than one day
85	5	23	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation School teacher
11. Industry or business Balto. City

FATHER
12. Name John Wightman
13. Birthplace Unknown

MOTHER
14. Maiden Name Emily Israel
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. E. J. Stegman
(b) Address 303 Tunbridge Rd.

17 (a) Burial (b) Date thereof 3/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 25 1946

19 (a) (b) Washington Williams, M.D.
(Date rec'd by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22, 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1938 to 3/22 1946 and that I last saw her alive on 3/22 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 yrs
Due to Arterio-sclerosis Myocarditis	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Boody M.D.
Address 1403 Parkave Date signed 3/24/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G38683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hours
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Cedar Croft Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Gardner Hawkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife James M. Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1867

8. AGE: Years	Months	Days	If less than one day
78	9	4	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. Larkin Gardner
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Susan Anderson
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. J. Harry Schisler
(b) Address 301 Cedarcroft Rd.

17 (a) Burial (b) Date thereof 3/25/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 3/25 1946 (b) Washington Williamsport
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1946, at 5:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22nd 1946, to March 23 1946, and that I last saw he alive on March 23rd 1946

Immediate cause of death	Duration
Heart failure	12 hours
Due to H C-V Disease	
Due to Arteriosclerosis	
Other Conditions Chronic colecystitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzales M. D.
Address Maryland G. Hospital Date signed

VS 150

G38684 Stop Patterson Park

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38684 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 N. Ballington Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 N. Ballington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Sterbak

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Albert Sterbak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 17

8. AGE: Years: 72 | Months | Days | If less than one day: hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Joseph Miller
13. Birthplace: Austria

MOTHER
14. Maiden Name: Anna Nagus
15. Birthplace: Austria

16 (a) Informant: Elizabeth Paleth
(b) Address: 1417 N. Ballington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-28-46 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer
Location: Balto Md

18 (a) Funeral director: Frank Boarman Sons
(b) Address: 700 N Eutaw

19 (a) (b) Registrar

MAR 29 1946 Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to March 25 1946 and that I last saw her alive on March 23 1946.

	Duration
Immediate cause of death: Bronchopneumonia	2 days
Uremia	7 days
Due to: Bilateral Pyelonephritis	1 yr.?
Due to:	
Other Conditions: Rheumatoid arthritis	5 yrs.?

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Karl Grossman M. D.
Address: 1212 N. Patterson Date signed: 3/25/46

Please X

638685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 638685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6508 Brooke Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kucera

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
77	10		hr. min.

9. Birthplace Austria - Hungary (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Charles Le Dehn
13. Birthplace Austria - Hungary

MOTHER
14. Maiden Name
15. Birthplace Austria

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof Mar. 26 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Gracyalny
(b) Address 900 N. Chester St.

MAR 25 1946 (Date rec'd by registrar)

(b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22, 1946 at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Trauma
due to extensive burns -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 22, 1946 at M.
(b) Where did injury occur? 6508 Brooke Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? [illegible]
(d) Means of injury clothes caught fire while burning

23. Signature Chester S. Lubinski M.D. Medical Examiner
Date signed Mar. 25 1946 per Robert Le Gendre M.D.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - # 5 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Potomac St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine J. Retz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John B. Retz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Charlestown, W. Va. (Town, county, and state)

10. Usual Occupation Hswf.

11. Industry or business

FATHER 12. Name August Schultz

13. Birthplace Germany

MOTHER 14. Maiden Name Anna [illegible] Heck

15. Birthplace Virginia

16 (a) Informant Rosalie Jones - dght.

(b) Address 607 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601-05 E. Madison Street

19 (a) Date received by registrar MAR 27 1946 (b) Registrar Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/46 19 .. at 8 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22/46 19 .. to 3/22 1946 and that I last saw h[illegible] alive on 3/22 1946

Immediate cause of death Infarct - rgt. frontal lobe c subarachnoid hem - orrhage

Due to Generalized arterio - sclerosis —

Due to

Other Conditions Cardiac hyper trophy Obesity

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy: See above —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. H. O. Stedem Jr

Address Mercy Hosp Date signed 3/27/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

638687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

638687 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4212 Parkmont Ave
(If rural give location)
(e) Citizen of foreign country? Scotland (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Salisbury

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-6695

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Agnes Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1888

8. AGE: Years	Months	Days	If less than one day
57	11	0	hr. min.

9. Birthplace Glascow, Scotland
(Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Sidel Mfg. Co

FATHER
12. Name James Salisbury
13. Birthplace Scotland

MOTHER
14. Maiden Name Elisabeth McDonald
15. Birthplace Scotland

16 (a) Informant Mrs. Agnes Bouldin
(b) Address 601 E. 27th St

17 (a) Burial (b) Date thereof March 26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

(a) Signature of undertaker Harry Lee Williams, M.D.

MAR 25 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23- 1946, at 5 15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20- 1946 to 3-22- 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma - prostate	
Due to & generalized extension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Marsh M. D.
Address 1700 Eutaw Pl Date signed 3-23-46

G38688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38688 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street, City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Henry Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife

6 (c) If [illegible] give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1874

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Wisconsin (Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business

FATHER
12. Name John M. Sherman
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Jordan
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) [illegible] Washington Williams M.D. Registrar
(Date received by registrar) MAR 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch-24 1946, at 1-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch-10 1946 to Mch 24 1946, and that I last saw him alive on Mch 23 1946.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to: Chronic Myocarditis	2 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 3/25/46

63869 B 38689 63869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1634

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 951 West Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON FRIEDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June, 28, 1906

8. AGE: Years 39 | Months 8 | Days 25 27 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business: Grocer Business

FATHER
12. Name: Louis Friedman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Celia Caplan
15. Birthplace: Russia

16 (a) Informant: Lillian Friedman
(b) Address: 951 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26, 1946 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

(a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

MAR 25 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/46 19 , at 9:00 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/25/46 at 2 A. M.
(b) Where did injury occur? 951 W Franklin St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury 4 Gas burners on stove

23. Signature John Chiles M.D. Medical Examiner.
Date signed 3/25/46

X

G38690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G38690

Registered No. 638690

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1236 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Willis

3 (b) If veteran, name war /

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1885

8. AGE: Years 60 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Shanklin

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Eliza ???

15. Birthplace Balto. Md.

16 (a) Informant Levi Chase

(b) Address 1236 Division St

17 (a) Burial (b) Date thereof 3-26-1946 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Sullivan

(b) Address 1631 Division St.

19 Mar 25 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 22 1946, at 37 M

21. I certify that death occurred on the date above stated; that I attended deceased Sept 4 1945 to Mch 21 1946 and that I last saw her alive on Mch 21 1946

Immediate cause of death

Cardio Vascular Renal Disease — Duration 4 yrs

Due to

Due to

Other Conditions Hemiplegia — Duration 3 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L Boteughs M. D.

Address 1643 Druid Hill Ave Date signed Mch 25/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38691 G38691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. 438691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1032 N. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie A. Dixon

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4 Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1891

8. AGE: Years 54 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Kelford, N. C. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name ? ? Jenkins
15. Birthplace N. C.

16 (a) Informant George Clark
(b) Address 1611 Abbott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George M. Holland
(b) Address 1631 Druid Hill Ave.

MAR 26 1946 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/1946, 11:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9/21 1946, to 3/22/1946, and that I last saw h[illegible] alive on 3/21/1946

Immediate cause of death Pulmonary T-B — Duration 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 450 W. Biddle St. Date signed 3/25/46

G38692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38692 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 Hamburg Stred
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 W Hamburg
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Day Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1901

8. AGE: Years	Months	Days	If less than one day
45	—	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Bell
13. Birthplace Washington D.C

MOTHER
14. Maiden Name Eliza Wilson
15. Birthplace Baltimore

16 (a) Informant Louis Wilson
(b) Address 208 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Sarah L Brumpton
(b) Address 108 W Monty omery St
Huntingtown Calvert Co Md

MAR 27 1946 (Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/1946 at 6 40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20/1946 to 3/21/1946 and that I last saw h alive on 3/20/1946

Immediate cause of death Pulmonary Tuberculosis — Duration 4 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Schneider M. D.

Address 1211 Lee Date signed 3/23/46

X

G38693 37421D

BALTIMORE CITY HEALTH DEPARTMENT X G38693

CERTIFICATE OF DEATH 157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Houston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 - 9th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gayland Gilliam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-41

8. AGE: Years	Months	Days	If less than one day
5	2	23	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wayland Gilliam
13. Birthplace Texas

MOTHER 14. Maiden Name Ruth Gilliam
15. Birthplace Texas

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 / 28 / 46 (month) (day) (year)
(c) Cemetery or crematory Brookside Memorial
Location Houston Texas

18 (a) Funeral director John O Mitchell Est.
(b) Address 1900 Eutaw Place
(c) Baltimore Md.
MAR 26 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946 at 6 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1946 to March 24 1946 and that I last saw him alive on March 24 1946

Immediate cause of death Cardiac failure — Duration 30 min.

Due to Tetralogy of Fallot — 5 yrs.

Due to

Other Conditions Probable pulmonary infarct

(Include pregnancy within 3 months of death)

Date of operation 3-5-46

Major findings of operation: Congenital heart disease - pulmonary stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Young
Address Johns Hopkins Hosp. Date signed 3-24-46 M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Winchester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Winchester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: George Jacob Fohs

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-4675

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ella E. Fohs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1871

8. AGE: Years	Months	Days	If less than one day
75	2	12	hr. min.

9. Birthplace Newark N.J.
(Town, county, and state)
10. Usual Occupation Casting Inspector
11. Industry or business S.B. Sexton Co

FATHER
12. Name George Fohs
13. Birthplace France

MOTHER
14. Maiden Name Mary ------
15. Birthplace Unknown

16 (a) Informant Margaret J. Enos
(b) Address 2923 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 27 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director Harry A. Simmons
(b) Address 4204 Ridgewood Ave

19 MAR 26 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1946 at 3p. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943 to 3/23/46 19 and that I last saw h[illegible] alive on March 23 1946.

Immediate cause of death: Cerebral Embolism — Duration 1 month

Due to Chronic Cardio Renal — 20 yrs.

Due to Chronic Bronchitis with Asthma — 20 yrs.

Other Conditions Senile Pneumonia — 3 days

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph N. Zierler M. D.
Address 2301 E. Eager St Baltimore Md Signed 3/26/46

X Zierler

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

AB-998 638695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 65B

638695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Eley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24- 1883

8. AGE: Years	Months	Days	If less than one day
62	5	0	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Eley (D
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-46 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond, Virginia

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MAR 26 1946

MEDICAL CERTIFICATION AM

20. DATE OF DEATH March 24- 1946, at 7.30M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12- 1946, to 3-24- 1946 and that I last saw him alive on 3-24- 1946

Immediate cause of death	Duration
adrenal insufficiency	
Due to calcification + fibrosis of adrenals	
Due to	
Other Conditions Prostatitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: At above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Jernigan M. D.
Address Baltimore City Hosp Date signed 3-24-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1951

Registered No. G38696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Longwood Street
(c) Hospital or institution:

167

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Longwood Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theadosia E. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Franklin P. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1856

8. AGE: Years	Months	Days	If less than one day
89	7	13	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name George W. Hill
13. Birthplace Salisbury, Md.

MOTHER
14. Maiden Name Jane Stephens
15. Birthplace England

16 (a) Informant Mrs. Emma E. Smith
(b) Address 3036 Edmondson Ave.

17 (a) Burial (b) Date thereof 3/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Mamie C. Syfer
(b) Address 1600 W. North Ave.

19 (a) [illegible] (b) Huntington Williams, M.D. Baltimore, Md.

MAR 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1946 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27, 1935 to Mar. 23, 1946 and that I last saw her alive on Mar. 23, 1946

Immediate cause of death	Duration
Cardiac Insufficiency	2 mon.
Due to	
Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene A. Knapp M. D.
Address 3030 Edmondson Ave. Date signed 3/25/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1340

Registered No. G38697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Mulberry St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County KENT
(c) City or town CHESTERTOWN
(If outside city or town limits, write RURAL and give town)
(d) Street No. CANNON
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME SARA L. THAWLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. H. THAWLEY
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 21 1893

8. AGE: Years 52 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace BORDEN CO. N. J.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ZAPHINRE BELL
13. Birthplace NEW. JERSEY

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Wm. H. THAWLEY
(b) Address CHESTEATOWN.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar. 28 1946 (month) (day) (year)
(c) Cemetery or crematory CHESTER CEM.
Location CHESTERTOWN - KENT Co. Md.

18 (a) Funeral director J. Willis Wells
(b) Address Chestertown, Md.

MAR 26 1946 (b) Huntington Williams, M.D.
(Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Mar 25 1946 and that I last saw h[er] alive on Mar 17 1946

Immediate cause of death Coronary Thrombosis — Duration

Due to Hypertension — Duration

Due to Bilateral cerebral Stroke — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Not operated Patient
Major findings of operation: Mar 17/46

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Guy L. Hunner M. D.
Address 110 N. State St Dly Date signed Mar 27 46

VS 150

GUY L. HUNNER X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38698 — BALTIMORE CITY HEALTH DEPARTMENT — G38698

CERTIFICATE OF DEATH 194a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2527 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (d) FULL NAME Christina Hartman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife John C. Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25. 1872

8. AGE: Years 73 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Andrew Eber
13. Birthplace Germany

MOTHER
14. Maiden Name Florence J. Kispert
15. Birthplace Germany

16 (a) Informant Annetta Ida Day
(b) Address 2408 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 27 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Chas. Wm. John H. Feuchtenberger Son
(b) Address 601 W. Fayette St

19 (a) Date received MAR 26 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946, at 7:30 a.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1946, to 3/24 1946, and that I last saw her alive on 3/24 1946.

Immediate cause of death: Coronary Occlusion — Duration 1 day

Due to: Arteriosclerosis and hypertension — 11 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D O'Malley M. D.
Address 336 Fremont Ave Date signed 3/25/46.

G38693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164D

G38693

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 E. Baltimore St.
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Floyd Edward Leeson

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-9840

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mabel E. Leeson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 FEB 1897

8. AGE: Years	Months	Days	If less than one day
49	1	20	hr. min.

9. Birthplace West County, W. Virginia (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Western Electric

FATHER
12. Name Marcus Leeson
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Nancy C. Hunter
15. Birthplace W. Virginia

16 (a) Informant Lillian F. Keller
(b) Address 3910 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director E. Haworth Limmer
(b) Address 3711 Liberty Heights Ave

19 MAR 26 1946 (b) (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1946, at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Insp thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Lin death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cut throat with severance of large arteries and trachea.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-24-46 at 1 A.M.
(b) Where did injury occur? 3400 E. Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Lower While at work? No.
(d) Means of injury Stabbing - self inflicted

23. Signature Benedict Steinecke M.D. Medical Examiner.
Date signed 3-24-46

Huntington Williams M.E.

Liv 4414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

638709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1921 E. Fairmount Ave
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Estelle Leeson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Floyd E. Leeson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/26/1899

8. AGE: Years 46 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Wirt County, W. Virginia (Town, county, and state)

10. Usual Occupation Urban Laundry

11. Industry or business

FATHER
12. Name Phillip Sheridan
13. Birthplace Kansas

MOTHER
14. Maiden Name Alice Underwood
15. Birthplace W. Virginia

16 (a) Informant Charles W. Malone
(b) Address 4815 Sinsdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Ellsworth Memorial
(b) Address 3911 Liberty Heights Ave.

MAR 26 1946 (Registered by registrar)

(b) Washington Hillegeas, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1946, at 3'9 P.M.

21. I certify that I took charge of the remains described above, held an Insp + Inq (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cut throat with severance of large arteries and trachea.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-24-46 at 1 P. M.
(b) Where did injury occur? 3400 E. Balto St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbed

Signature Benedict Skotarelis M.D. (Medical Examiner)
Date signed 3-24-46

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G38701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 32nd Sts.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. University Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida M. Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed Married

6 (b) Name of husband or wife Wm. A. S. Marshall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None. Housewife
11. Industry or business

FATHER
12. Name Henry Wedi
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Zimmerman
15. Birthplace Maryland

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 3/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director Ellsworth Armacost
(b) Address 3211 Liberty Heights Ave.
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MAR 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946 at 8 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1946 to 19 and that I last saw her alive on March 23 1946.

Immediate cause of death: Coronary occlusion with myocardial infarction — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford T. Kirkpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 3-23-46

X Kirkpatrick

G38702
AB-100070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G38702
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Turners Stations
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 Flicker Ct-Turners Station
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John ~~Peterson~~ PETERS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2- 1876

8. AGE: Years 70 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John ~~Peterson~~ (D Peters
13. Birthplace Md.

MOTHER
14. Maiden Name Jane ? (D
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-46 (month) (day) (year)
(c) Cemetery or crematory F. Baltimore Elm
Location A. A. 60

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 638 N. Gilmor St.

19 (Date received by local registrar) MAR 26 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH March 24- 1946, at 2.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21- 1946 to 3-24 1946.
and that I last saw him alive on 3-24- 1946.

	Duration
Immediate cause of death: PERFORATED Peptic Ulcer With Generalized Peritonitis	3 days
Due to: Diabetes Mellitus	Unknown
Due to: Gangrene Rt. Foot	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
Findings of autopsy ~~Confirmed clinical diagnosis~~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rush E. Nellenbach M. D.
Address Balt. City Hosp. Date signed 3-25-46

G38703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G38703 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 days
(e) Length of stay in Baltimore (yrs., mos., or days): 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Texas (b) County:
(c) City or town: Fort Worth (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2722 Rosen Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Millican, Jimmy Charles

3 (b) If veteran, name war:
3 (c) Social Security Account No.: 450-32-2707

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 18, 1928

8. AGE:	Years	Months	Days	If less than one day
	17	7	16	hr. min.

9. Birthplace: Ft. Forth, Texas (Town, county, and state)
10. Usual Occupation: Ordinary seaman
11. Industry or business: Seafarer

FATHER
12. Name: Charles F. Millican
13. Birthplace: Oklahoma

MOTHER
14. Maiden Name: Opa Montgomery
15. Birthplace: Miss.

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Fort Worth
Location: Texas

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) (Date rec'd by registrar) MAR 26 1946 (b) Huntington Williams, M.D.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 24 1946 at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1946 to Mar. 24 1946 and that I last saw him alive on Mar. 24 1946.

Immediate cause of death: Squamous cell carcinoma of tonsil — Duration: 2 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 3/25/46
US Marine Hospital, Balto, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638704

AB-100091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90B

638704-

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2361 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Durwin (Darwin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife: Annie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24- 1881

8. AGE: Years	Months	Days	If less than one day
64	4	29	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Durwin (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Walker (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. Roberta Elliott Daugherty
(b) Address 1129 N. Carlisle St

19 MAR 26 1946 (b) [redacted] Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23- 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22- 1946, to 3-23- 1946, and that I last saw h im alive on 3-23- 1946

Immediate cause of death	Duration
Pneumonia Pericarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: At above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigon M. D.
Address Baltimore City Hosp. Date signed 3-27-46

VS 150

G38705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G38705 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Reed

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Wid

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-70

8. AGE: Years 75 | Months 2 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Levi Blake
13. Birthplace Va

MOTHER 14. Maiden Name Rachel ?
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Saml L Brauns Son
(b) Address 108 W Monument Street

19 (a) (b) Registrar

MAR 26 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946 at 10 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1946 to Mar 22 1946 and that I last saw her alive on Mar 22 1946

Immediate cause of death	Duration
Cardiac failure	24 hrs
Due to	
Due to	
Other Conditions Carcinoma of stomach (Include pulmonary within 3 months of death)	6 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Paul Hoggins M. D.
Address Johns Hopkins Date signed 23 Mar 46

1 Boyd. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. 638705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Levi

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Wd

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/2/1871

8. AGE: Years 75 | Months - | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wally Frazier
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Margaret Johnson
(b) Address 1701 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Maryland

18 (a) Funeral director George U. Kelson
(b) Address 1303 E. Eastman St.

MAR 26 1946 (a) (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946 at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to 3/25 1946 and that I last saw h[illegible] alive on 3/24 1946

Immediate cause of death Cardiac Renal — Duration 1 Mo

Due to — Duration 25 d

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. N. Hatcher M. D.

Address 1725 Park Ave Date signed 3/26/46

638707 BALTIMORE CITY HEALTH DEPARTMENT 1946 638707
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George E. Schaffer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Jennie G (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1886

8. AGE: Years 59 | Months 6 11 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business B & O R R

FATHER 12. Name George J Schaffer

13. Birthplace Md

MOTHER 14. Maiden Name Minnie Reisinger

15. Birthplace Md

16 (a) Informant Mrs G E Schaffer

(b) Address 2309 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto Md

18 (a) Funeral director Geo C Conley

(b) Address Fulton & Fayette

19 MAR 26 1946 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23- 1946, at 2.30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skiteraki M.D. Medical Examiner.
Date signed 3-24-46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G38708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 N. Carey
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Henry Gray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Fletcher Dixon

13. Birthplace md

MOTHER 14. Maiden Name Anna Lewis

15. Birthplace md

16 (a) Informant Emma Dixon

(b) Address 701 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-46 (month) (day) (year)

(c) Cemetery or crematory Brooks Cal. Co. Md

Location

18 (a) Funeral director James A Hayes

(b) Address 1042 Wetzel St

19 MAR 26 1946 (b) Signature of Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1945 to Mar 25 1946, and that I last saw her alive on: Mar 23 1946

Immediate cause of death: Cardiac insufficiency — Duration: 3 mos.

Due to: Hypertension — 2 yrs

Due to: Cirrhosis of Liver — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Douglas Shepperd M. D.

Address 1431 Druid Ley Date signed 3-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 494

G38709 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Hudson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine Lambert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Leo

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Gerald Griffin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Leona Jefferson
15. Birthplace Baltimore Md.

16 (a) Informant Leo Lambert
(b) Address 2731 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location O'Donnell Street

18 (a) Funeral director John J. Duda
(b) Address 2824 Hudson St.

19 (MAR 26 1946 Registrar for Millington Md)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1946, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1946 to 3/24 1946 and that I last saw her alive on 3/24 1946

Immediate cause of death	Duration
Ovarian Malignancy with Carcinomatosis	18 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation March 16 1945

Major findings of operation: Ovarian neoplasm

of autopsy: Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Gordon

Address Sinai Hospital Date signed 3/24/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/3B

G38710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 W. Saratoga st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ardella Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Moore
13. Birthplace Maryland

MOTHER
14. Maiden Name Estelle Dixon
15. Birthplace Maryland

16 (a) Informant Mrs Osie Carter
(b) Address 922 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Hatsley
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) MAR 26 1946 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1946, at 2:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculous caseous pneumonia

Due to Tuberculosis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarchic M.D. Medical Examiner.
Date signed 3-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Hermosa Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Shull

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William A. Shull
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1879

8. AGE: Years	Months	Days	If less than one day
66	7	27	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Andrew J. Stone
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name not known
15. Birthplace Carroll Co. Md.

16 (a) Informant Husband
(b) Address 1311 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) MAR 26 1946 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946 2:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1946 to March 24 1946 and that I last saw h[illegible] alive on 3/24/46 19

Immediate cause of death	Duration
General asthenia Edema	3 yrs
Chronic myocarditis	3 yrs
Due to Bronchopneumonia	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon, M.D.
Address 29 S. Broadway Date signed 3/25/46

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

Registered No. G38712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2925 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma V. Fairbanks.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Wilbur Fairbanks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1876.

8. AGE: Years	Months	Days	If less than one day
70	0	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business At home.

FATHER
12. Name Chas. L. Cunningham.
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown

16 (a) Informant Mr. Walter Cunningham
(b) Address 2925 Frederick Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 3/27/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 505 N. Monroe St.

19 (a) (Date received by registrar) (b) Registrar

MAR 26 1946

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH March 24 — 1946 at 3. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1945 to 3/24 1946, and that I last saw her alive on 3/24 1946

Immediate cause of death	Duration
Repeated Myocardial infarcts	1 day
Due to	
Due to	
Other Conditions Arteriosclerosis	7.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Pellegrin

Address 336 Fallsway Date signed 3/25/46 M. D.

X

G38713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38713 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 Juniper Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Juniper Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET STOLTE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Richard Stolte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1862

8. AGE: Years	Months	Days	If less than one day
83	9	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Arndt
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. E. Paul Behles
(b) Address 3808 Juniper Rd. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b)

MAR 26 1946

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Mar. 23, 1946, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 8 1946, to Mar 23 1946, and that I last saw h[illegible] alive on Mar 22 1946.

Immediate cause of death Coronary Occlusion — Duration 15 days

Due to

Due to

Other Conditions Myocarditis Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Arnberg M. D.
Date signed 3/25/46

Huntington Williams Md. 721 Medical Arts

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 Kennedy Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Kennedy Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LeRoy Renolds Zimmerman

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen H. Zimmerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1890

8. AGE: Years	Months	Days	If less than one day
55	10	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Bread Salesman

11. Industry or business

FATHER
12. Name John Charles Zimmerman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Susan Askey
15. Birthplace Baltimore

16 (a) Informant Mrs. Helen H. Zimmerman
(b) Address 1922 Kennedy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 26 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1946 at 10:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1946 to March 22 1946 and that I last saw him alive on March 22 1946.

Immediate cause of death Coronary Thrombosis

Due to Chronic Myocarditis

Due to

Other Conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3801 Shannon Drive Date signed 3/25/46

Huntington Hilltop

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G38715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 120 days
(e) Length of stay in Baltimore (yrs., mos., or days) 120 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town (Greenhaven) Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. West Shore Rd.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country

3 (a) FULL NAME Clement, William

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-16-0222 / 558-16-9479

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 21, 1874

8. AGE: Years	Months	Days	If less than one day
71	8	3	____ hr. ____ min.

9. Birthplace ? Germany (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafarer

MOTHER / FATHER
12. Name Frank Clement
13. Birthplace Germany
14. Maiden Name Theresa ?
15. Birthplace Germany

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)
(c) Cemetery or crematory Glenhaven Cem.
Location Glenhaven, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ____ (Date rec'd by registrar) (b) MAR 26 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24 1946, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1945, to Mar. 24 1946, and that I last saw him alive on Mar. 24 1946.

	Duration
Immediate cause of death: Pneumonia, bronchial, right lower lobe	few days
Other condition: Due to Cardiac hypertrophy with failure	UNKNOWN
Other condition: Due to Arteriosclerosis, general	UNKNOWN
Other Conditions: Endocarditis, chronic aortic valve	UNKNOWN

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Clinical Director Date signed 3/25/46
US Marine Hospital, Balto, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. 63871.6

~~63871.5~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 363 W. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Edwards Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19- 1877

8. AGE: Years	Months	Days	If less than one day
68	8	6	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert
13. Birthplace ?

MOTHER
14. Maiden Name Carrie Williams
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof March 29 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Highland Chapel
Location Howard Co., Md.

18 (a) Funeral director Robert F. Snowden
(b) Address Rockville, Md.

19 (a) MAR 26 1946 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25- 1946, at 6.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19- 1946 to 3-25- 1946 and that I last saw him alive on 3-25- 1946.

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerotic Heart Disease.

Due to

Other Conditions Asthma.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Fauber, Jr. M. D.
Address Balt. City Hosp. Date signed 3-25-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38717 G38717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 676 Haw Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 676 Haw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1885

8. AGE: Years	Months	Days	If less than one day
60	9	12	hr. min.

9. Birthplace Anne Arundel County Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name John Jackson
13. Birthplace Anne Arundel County Md

MOTHER
14. Maiden Name Lizzie Watkins
15. Birthplace Anne Arundel County Md

16 (a) Informant Richard Jackson (Son)
(b) Address 676 Hill Street

17 (a) [illegible] (b) Date thereof March 29 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Anne Arundel County [illegible]
Location

18 (a) Funeral director Joseph A. Lively
(b) Address 4620 Mount Street

19 (a) (b)
(Date received by registrar) Registrar

VS MAR 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1946, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1946, to Mar 24 1946, and that I last saw h[illegible] alive Mar. 23 1946.

Immediate cause of death Acute Uraemia — Duration 2 Wks

Due to Chr. Nephritis and Renal Lithiasis — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Gainey M. D.
Address 527 W. Hamburg St Date signed 3/25/46

G38718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G38718

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 W. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEARY O'NEILL SHIPLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel M. Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1899

8. AGE: Years	Months	Days	If less than one day
46	7	17	hr. min.

9. Birthplace Harford Co.
(Town, county, and state)
10. Usual Occupation Sales Mgr.
11. Industry or business Southern Wholesalers

FATHER
12. Name Alexander Shipley
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name E. Mae Geary
15. Birthplace Harford Co.

16 (a) Informant Mrs. Ethel M. Shipley
(b) Address 2806 W. Rogers Ave.

17 (a) Burial (b) Date thereof 3/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 26 1946 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24, 1946, at 5:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Mar.~~ 24 1946 to 19
and that I last saw h alive on 19

Immediate cause of death — Duration
Coronary Thrombosis — 4 hrs.
Due to
Due to
Other Conditions Cardio Vascular disease
(Include pregnancy within 3 months of death).
Date of operation July 45
Major findings of operation:
Depressed fract.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frank C. Marino M. D.
Address 1129 St Paul Date signed Mar 27 46

Howard J. Mengis, M.D.

G38719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. G38719

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 E Oliver St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Miller (MARY FRANCIS MILLER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife George W. Miller
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	2	8		1877

9. Birthplace Baltimore md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Gray
13. Birthplace Balto. md.

MOTHER
14. Maiden Name Maria Deaver
15. Birthplace md.

16 (a) Informant Mr. Irving B. Gray
(b) Address 815 Hollen Road - 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 26 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1946 at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1946 to 3-24 1946 and that I last saw h[illegible] alive on 3-24 1946

Immediate cause of death	Duration
Carcinoma Sigmoid Colon	6 (?) mos
Metastasis to Liver	
Due to Lymph nodes, Sigmoid Tumor	
Due to	
Other Conditions Probable Coronary Thrombosis	10 hours

(Include pregnancy within 3 months of death)
Date of operation 3-19-46
Major findings of operation: As above
of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard T. Kurland M. D.
Address Date signed 3-25-46

VS 150

X

G38720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38720 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 S. Decker Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 921 S. Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Rathgeber

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Rathgeber
6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): May 6, 1869

8. AGE: Years: 76 | Months: 10 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Handyman, Ret.

11. Industry or business: Standard Oil Co.

FATHER
12. Name: John Rathgeber
13. Birthplace: Germany

MOTHER
14. Maiden Name: Teresa ?
15. Birthplace: Germany

16 (a) Informant: Mrs. Rose Rathgeber
(b) Address: 921 S. Decker Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/27/46 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 26 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 March 1946 at 11 20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: William S. Gleich M.D. (Medical Examiner.)
Date signed 25 March 46

VS 151

G38721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G38721 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Kavanagh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Francis ~~Sexton~~ Saron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 - 1902

8. AGE: Years	Months	Days	If less than one day
24	11	-	hr. 1921 min.

9. Birthplace St Marys Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Thomas ~~Saxton~~ Saron
13. Birthplace St Marys Co.

MOTHER
14. Maiden Name Lee ~~Emmels~~ Ennels
15. Birthplace St Marys Co.

16. (a) Informant Paul ~~Emmels~~ Ennels
(b) Address 706 Mosher St

17 (a) Burial (b) Date thereof 3-28-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Great Mills, St. Mary Co., Md

18 (a) Funeral director Pius B. Robinson
(b) Address Dameron, Md.

19 Filed MAR 26 1946 by Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1946 at 3:20 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of neck.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-24-46 at 1:50 A. M.
(b) Where did injury occur? 1707 Lorman ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot by Tavern-Keeper.

23. Signature Benedict Sbitanelic M.D.
Medical Examiner.
Date signed 3-24-46

G38722
AB-99599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38722
Registered No. 1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 167
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard James Ralph

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-0158

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31-1894

8. AGE: Years	Months	Days	If less than one day
51	9 11	24 25	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James R. Ralph
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-46 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Md.

18 (a) Funeral director Lennon & Chase & Son
(b) Address 638 N. Gilmor

MAR 26 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at 3:45 AM

21, I certify that death occurred on the date above stated; that I attended deceased from 2-28- 1946, to 3-25- 1946, and that I last saw h 1m alive on 3-25- 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration ?
Due to
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 3/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38723 BALTIMORE CITY HEALTH DEPARTMENT 470 G38723

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 714
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
City or town
(If outside city or town limits, write RURAL and give town)
(c) Street No. 916 Shutter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES CLARK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1895

8. AGE: Years	Months	Days	If less than one day
50	mt 10	2	hr. min.

9. Birthplace Farmville, Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Archer Clark
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Elenora Clark
(b) Address 919 Shutter St

17 (a) Burial (b) Date thereof 3/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pleasant Alley
Date rec'd MAR 26 1946 (Huntington Williams) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/46 19 , at 4:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Generalized Carcinomatosis

Due to
Bronchogenic Carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 63 B

638724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. a. 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Bellamy

3 (b) If veteran, name war

3 (c) Social Security Account No. 224-26-153

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace Tarboro N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name	William Bellamy
FATHER — 13. Birthplace	N. C
MOTHER — 14. Maiden Name	Corena Hines
MOTHER — 15. Birthplace	N. C.

16 (a) Informant Annie Bailey
(b) Address 1611 W. Lanvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Webley
Location Tarboro N. C.

18 (a) Funeral director Smith Alexander
(b) Address 927 N. Mount St

19 (a) (Date received by local registrar) MAR 26 1946 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at 8 20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Edema
Cardiac Hypertrophy, slight
Hyperthyroidism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

D. Signature Robert L. Graham M.D. Medical Examiner.
Signed March 25 1946.

G38725 Vol Ke G38725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dwelling 6 Caton aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (Bloomsbury Ave.) General Delivery
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip C. Volke

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Carrie Sohn Volke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 1874

8. AGE: Years	Months	Days	If less than one day
71	4	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Cabinet maker
11. Industry or business General Cabinet repairing Catonsville Md.

FATHER
12. Name Frederick Volke
13. Birthplace Md

MOTHER
14. Maiden Name deceased (Unknown)
15. Birthplace

16 (a) Informant Mrs. Carrie Sohn Volke
(b) Address Bloomsbury Ave., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Evangelical Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1946 to 3/24 1946, and that I last saw him alive on 3/24 1946.

Immediate cause of death Cardiac failure

Due to Coronary thrombosis

Due to

Other Conditions Pulmonary congestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Cleff Calliff, Jr. M.D.
Address St Agnes Hosp Date signed 3/24/46

VS 150 This is a duplicate Certificate

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38726 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Dolan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Peter A Dolan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7 1887

8. AGE: Years 58 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name John Conroy

13. Birthplace Ireland

MOTHER 14. Maiden Name Annie Murphy

15. Birthplace Ireland

16 (a) Informant Peter A Dolan

(b) Address 1907 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director John G Moran

(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS MAR 26 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946, at M

21. I certify that death occurred on the date above stated, that I attended deceased from March 15 1942 to March 24 1946, and that I last saw h C.R. alive on Mar. 24 1946.

Immediate cause of death: CHRONIC Myocardial valvular disease — Duration: 3 yrs

Due to: Essential Hypertension — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work?
(e) Means of injury

23. Signature [signature]

Address 521 [illegible] Ave Date signed 3/26/46

Huntington Pathological Lab

G38727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G38727 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 Wilmot Ct
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) no 17
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 Wilmot Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Premature Baby Girl Bruce

3 (b) If veteran, name war —
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Ne	S

6 (b) Name of husband or wife no
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/20/46

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation no
11. Industry or business —

FATHER
12. Name Thos Joseph
13. Birthplace Md

MOTHER
14. Maiden Name Mary Bruce
15. Birthplace Md

16 (a) Informant Mary Bruce
(b) Address 1036 Wilmot Ct

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loc Johns Hopkins Medical School MAR 26 1946

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 26 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/1946 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1946 to 3/20 1946, and that I last saw h— alive on 3/19 1946

Immediate cause of death Prematurity — Duration —
Due to — —
Due to — 3d
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. D. Hecht M.D.
Address 1 W ES Pk Ave Date signed 3/20

VS 150

F 3382

G38728

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G38728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs. 52 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Mount Victoria
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Crain

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/46

8. AGE: Years | Months | Days | If less than one day: 4 hr. 52 min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Bennett Crain
13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Helen Hampton Young
15. Birthplace Balto., Md.

16 (a) Informant Bennett Crain
(b) Address Mt. Victoria, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 26 1946

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 26 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

3381

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1946, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1946, to 3/25 1946, and that I last saw him alive on 3/25 1946.

	Duration
Immediate cause of death: Congenital atelectasis Bilateral	4 hrs. 52 min.
Due to: Prematurity - 31 wks	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Acken, M.D. M. D.
Address Hosp. for Women of Md. Date signed 3/25/46

G38729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38729 / 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. County
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 87 College Creek Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rinder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-46

8. AGE: Years	Months	Days	If less than one day
			20 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh Rinder
13. Birthplace Md.

MOTHER
14. Maiden Name Marian Addison
15. Birthplace Md

16 (a) Informant Parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 26 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) M&D 26 1946 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

3383

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 16 1946 at 5.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946, to March 16 1946, and that I last saw h.. alive on March 16 1946

Immediate cause of death Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Morrison Jr. M.D.
Address Johns Hopkins Hosp. Date signed 3/26

X

G38730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38730

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Dihedral Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Lowell

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/23/46

8. AGE: Years | Months | Days | If less than one day: 10 hr. 54 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Victor Lowell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Blanche Lowell
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Blanche Lowell
(b) Address 22 Dihedral Drive.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 MAR 26 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

Johns Hopkins Medical School MAR 26 1946 Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946, at 10 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1946, to 3-23- 1946, and that I last saw h/im alive on 3-23 1946

Immediate cause of death: Congenital Heart Defect — Duration: 10 hours
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Bobby L. Lowe M. D.
Address Franklin Sq. Hosp. Date signed 3/23/46

VS 150

3384

G38731 52-99547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G38731 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) ✓ Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Beard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1924

8. AGE: Years	Months	Days	If less than one day
22	0	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Augustr Wienhold
13. Birthplace Md.

MOTHER
14. Maiden Name Marguerite Mullen
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1446 Light St.

19 (a) (Date rec'd by registrar) (b)

MAR 26 1946

Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1946 at 5:55P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1946, to March 23 1946, and that I last saw her alive on March 23 1946.

Immediate cause of death	Duration
Pulmonary Tuberculosis	4 years
Due to	
Due to	
Other Conditions Tuberculous Laryngitis	Recent.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jarrigor M. D.
Address Baltimore City Hosp. Date signed 3-29-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1061 B

G38732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary ~~Palamenna~~ Reilly (~~Palamenna~~)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
fe	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21. 1873

8. AGE: Years	Months	Days	If less than one day
72	4	4	hr. min.

9. Birthplace Newark, N. J.
(Town, county, and state)

10. Usual Occupation Trained Nurse

11. Industry or business

FATHER
12. Name Thomas Reilly
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary ?
15. Birthplace New Jersey

16 (a) Informant Mrs. Gladys Lighter
(b) Address Aberdeen, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ritz Wiedefeld
(b) Address 914 Greenmount Ave

MAR 26 1946 Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th 1946, at 8:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1946, to March 25 1946, and that I last saw her alive on March 25 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Chronic Emphysema	
Due to Congested failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Frawley M. D.
Address Maryland General Hospital Date signed 3/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1892

Registered No. 638733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Maryland Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months in hospital

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sherman P. Eyler

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Helen P. Herbert
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 27 Oct 1901

8. AGE: Years	Months	Days	If less than one day
44	4	29	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Laborer: Consolidum Yarn Co.
11. Industry or business Eldersburg, Md.

FATHER
12. Name Parke Eyler
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Beard
15. Birthplace Md.

16 (a) Informant Howard Herbert
(b) Address Finksburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or ~~crematory~~ Methodist Cem.
Location Finksburg, Md.

18 (a) Funeral director H. Bankard Sons
(b) Address Westminster, Md.

19 (a) MAR 27 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1946, at 10:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 17 MAR 1946 to 3/26 1946, and that I last saw him alive on 3/26 1946

Immediate cause of death Meningitis, mastoiditis, Basilar

Due to Abscess in region of right mastoid

Due to otitis media

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Luther Bennefield, M.D.
Address Md. Date signed 3/26/46 M. D.

(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38734
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Butler (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N. Maine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milford Vensel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 3-17-05

8. AGE: Years	Months	Days	If less than one day
41	11	9	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name John H Vensel
13. Birthplace Pa

MOTHER
14. Maiden Name Hannah Bamhardt
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Butler Penn
18 (a) Funeral director Wm G Fichter & Son
(b) Address North & Penna Ave
MAR 27 1946 (Date rec'd by Registrar) (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 7.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1946, to March 26 1946 and that I last saw him alive on March 26 1946.

Immediate cause of death	Duration
Carcinoma, ca-cinoma rt. parotid gland & cerebral metastases	? 1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/16/45 3/12/45 2/28/46
Major findings of operation: Ca. rt parotid gland
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Bruce J. Fraus
Address The Johns Hopkins Hosp. Date signed 3/26/46 D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 Parkmont Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Parkmont Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILLIP HACK

3 (b) If veteran, name war W

3 (c) Social Security Account No. ann

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1861

8. AGE: Years	Months	Days	If less than one day
84	5	25	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation Retired Car Inspector

11. Industry or business B & O R.R.

FATHER
12. Name Unknown Hack
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Clyde M. North
(b) Address 2504 Taylor Ave

17 (a) Burial (b) Date thereof 3/26/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 27 1946 Huntington Williams, M.D.
Registrar

VS 151 -

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/46 19 at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 3/26/46

G38736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G38736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor
(c) Hospital or institution West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 N. Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida May Mocarsky

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6. (b) Name of husband Alexander Mocarsky
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 1st 1887

8. AGE: Years	Months	Days	If less than one day
58 59	5	25	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Chas. N. Lucas
13. Birthplace Md.

MOTHER
14. Maiden Name Katharine Bonner
15. Birthplace St. Louis Mo.

16 (a) Informant Alexander McKarsky
(b) Address 1028 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co., Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 27 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 March 1946, at 6:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Mar 1946 to 26 Mar 1946 and that I last saw her alive on 26 Mar 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Edema and Stenosis	
Due to Hypertensive C.V. Renal Dis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leslie Stacey M.D.
Address West Balto Gen Hosp Date signed 3/27/46

VS 150

G38737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1642

Registered No. G38737

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Pelham Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 3114 Pelham Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard H. Lissau

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-3595

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Elizabeth Katz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1886

8. AGE: Years	Months	Days	If less than one day
59	9	16	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Richard C Lissau
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Christ
15. Birthplace Germany

16 (a) Informant Mrs Elizabeth Lissau
(b) Address 3114 Pelham ave

17 (a) Burial (b) Date thereof March 28 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey, Md.

18 (a) Funeral director Henry H Wittle
(b) Address 4101 Edmondson Ave

19 (a) MAR 27 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1946, at 7.45 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia by Strangulation

Due to

Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/25/46 about 1.00 P.M.
(b) Where did injury occur? 3114 Pelham Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Hung self with rope in Kitchen

23. Signature J. P. Pulaski M.D.
Medical Examiner.
Date signed 3/25/46

G38738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38738 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Parksley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Parksley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Long

3 (b) If veteran, name war

3 (c) Social Security Account No. 218 18 3539

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth L. Long

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1873.

8. AGE: Years 72 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Retired 5yrs.

11. Industry or business Plasterer

FATHER
12. Name Louis G. Long
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Woods
15. Birthplace Va.

16 (a) Informant Mrs. Elizabeth L. Long
(b) Address 506 Parksley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 27/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Kirkpatrick
(b) Address 4101 Edmondson Ave.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

MAR 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23/46. 19 at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1941 to 3/23 1946 and that I last saw him alive on 3/23 1946

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Cardio-Vascular Disease — Duration: 5 Years

Due to: — Duration:

Other Conditions: Carbuncle of Hemorrhage — 4/9/41

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eliot W. Johnson

Address 5432 Frederick Ave. Date signed 3/28/46

G38739 2 Mans.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193 D

Registered No. G38739

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 S. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 S. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida Schultheis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1880

8. AGE: Years 65 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Andrew Martin
13. Birthplace Md.

MOTHER
14. Maiden Name Elisabeth Clay
15. Birthplace Md.

16 (a) Informant Mrs. Ida Martin
(b) Address 210 S. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Lutzke
(b) Address 4101 Edmondson Ave.

19 (Date received) MAR 27 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch. 23/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to March 23 1946 and that I last saw him alive on March 23 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arterio-Sclerotic Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Seagmeth M. D.
Address 1729 W Lombard St Date signed 3/25/46

VS 150

G38740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946

G38740 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dist.
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Hillman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Dorsey

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary McGah Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 6. 1875

8. AGE: Years: 71 | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual Occupation: Retired Laborer
11. Industry or business: Baltimore City Water Dept.

FATHER
12. Name: Michael Dorsey
13. Birthplace: Ireland

MOTHER
14. Maiden Name: not known
15. Birthplace: Ireland

16 (a) Informant: Mrs. Anna D. Sanford
(b) Address: 311 St. Paul place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 29. 1946 (month) (day) (year)
(c) Cemetery or crematory: Mt. Cathedral Cemetery
Location: 4300 Old Frederick Rd

18 (a) Funeral director: Edmund W. Conklin & Son
(b) Address: 924 E. Lager St.

19 (a) MAR 27 1946 (b) [illegible] Registrar
Registrar's signature: [illegible] Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1946, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: C. J. Gabrielski M.D.
Medical Examiner.
Date signed 3/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 B

638741 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring + Belvedere Aves
(c) Hospital or institution: Levindale Hebrew Home + Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring + Belvedere
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HYMAN DICKMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Faib
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant Mayer Dickman
(b) Address 209 N. High St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Prof Rd. Hamilton Ave

18 (a) Funeral director Paul Lewis Inc
(b) Address 1739 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Bldg

MAR 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1946 at 2:40 p M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1939 to 3-26 1946, and that I last saw h[illegible] alive on 3-26 1946.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Levin M. D.
Address Levindale Date signed 3-26-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38742 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: So. Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Solley (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Otis Jacobs
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Viola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29-1901

8. AGE: Years 44 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name George Jacobs
13. Birthplace Va.

MOTHER
14. Maiden Name Estelle Brown
15. Birthplace Va.

16 (a) Informant Viola E. Jacobs
(b) Address Solley A.A. Co. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 25 46 (month) (day) (year)
(c) Cemetery or crematory Maggoty Gen
Location A.A. County Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Luzerne Ave

19 (a) MAR 27 1946 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1946 at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9- 1946 to 3-25 1946 and that I last saw h alive on 3-25 1946

Immediate cause of death T Uremia — Duration

Due to Intestinal obstruction

Due to Post-operative adhesions

Other Conditions Sickle cell anemia, Atelectasis left lung, Kidney Stone
(Include pregnancy within 3 months of death)

Date of operation 3-9-46 & 3-24-46

Major findings of operation: Sclerosing pelvic Intestinal obstruction

of autopsy: ?

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] MD
Address 1213 [illegible] Date signed 3/27/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G38743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Riggs ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16?
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Riggs ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C Morris.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cornelius
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-13-1902

8. AGE: Years 43 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Cornelious Morris
(b) Address 1120 Riggs ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 27 46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore Co. Md

18 (a) Funeral director William A Simpson
(b) Address 916 [illegible] Washington Boulevard, Baltimore, Md.

19 (a) MAR 27 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-1946, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19/45 to 3/19/46, and that I last saw him alive on 3/19/46

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions Coronary Thrombosis

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature M. L. Barksdale M. D.
Address 526 N. Carey St. Date signed 3/26/46

M. L. Barksdale

V8 150

G38744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G38744

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6001 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6001 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTON STEYER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Marie Steyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1857

8. AGE: Years 88 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Anton Steyer
(b) Address 6001 Belair Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar. 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

MAR 27 1946 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th 1946, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22, 1946 to March 25 1946 and that I last saw h alive on March 25 1946

Immediate cause of death: Bronchopneumonia — Duration 3 days
Due to Chronic Myocarditis
Due to Arteriosclerotic Cardiovascular Renal Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Wolfe
Address 7321 E. North ave Date signed 3-26-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38745 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise S. Rice

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: fe | 5. Color or race: w | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry J. Rice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	8	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry C. Wall
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Laura Compton
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Almira Chenoweth
(b) Address 3614 W. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 27 1946 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th 1946, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1946, to March 25 1946, and that I last saw h-er alive on March 25 1946.

Immediate cause of death	Duration
Terminal pneumonia	
Due to Lymphatic Cancer	
Due to	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzales
Address Maryland G. Hospital Date signed 3/26/46

VS 150

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38746 — BALTIMORE CITY HEALTH DEPARTMENT — 931 — 638746 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D-4A
(b) Street address 4504 Fernhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Fernhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harootune V. Levonian

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rosalie Levonian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1871

8. AGE: Years	Months	Days	If less than one day
75	2	7	hr. min.

9. Birthplace Aintab, Turkey (Town, county, and state)
10. Usual Occupation D. D. S.
11. Industry or business Self

FATHER — 12. Name Unknown
13. Birthplace "

MOTHER — 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. R. D. Dauterich
(b) Address 422 Dunkirk Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 27 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1946, at 6 40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Interment Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. A. Sabinaki M.D. Medical Examiner.
Date signed 3/26/46

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

Registered No. G38747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: (Private)
(a) State Md (b) County Baltimore 14
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7814 Nelson Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Baby Girl Douglas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3.16.46

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace University Hospital Baltimore (Town, county, and state) Md
10. ~~Usual Occupation~~
11. ~~Industry or business~~

FATHER
12. Name Herbert Fillmore Douglas
13. Birthplace North Umberland Va

MOTHER
14. Maiden Name Anna Flaherty
15. Birthplace Baltimore, Md

16 (a) Informant Herbert Fillmore Douglas
(b) Address 7814 Nelson Ave. Balto 14 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Co. Md.

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 27 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1946, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3.18 1946, to 3.25 1946, and that I last saw h alive on 3.25 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral hemorrhage	2 days
Due to Congenital hemolytic disease of newborn	8 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas C. Braun Kelly M.D.
Address Univ. Hosp. Baltimore, Md. Date signed 3/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G38748 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution:
McKenna Memorial Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Glenwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Marie A. Ridgely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Widowed

6 (b) Name of husband or wife Wm A. Ridgely
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James Offutt
13. Birthplace Md.

MOTHER
14. Maiden Name — Merritt
15. Birthplace Md.

16 (a) Informant Mr. J. A. Ridgely
(b) Address Lyksville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-46 (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cem.
Location Glenwood, Md.

18 (a) Funeral director C. Harry Dew
(b) Address Lyksville, Md.

19 (a) (b) Registrar

Filed Mar 29 1946 Huntington Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 5:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from March 11 1946 to March 26 1946, and that I last saw h[illegible] alive on March 26 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Nephritis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Faucher M. D.
Address 1035 W. Calvert St. Date signed 3/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

638749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Vine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 VINE St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Deppish

3 (b) If veteran, name war none

3 (c) Social Security Account No. 219-03-1343

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elsie H. Deppish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1879

8. AGE: Years 67 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Brass Moulder

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Elsie H. Deppish

(b) Address 2107 Vine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28 1946 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem Co

Location City

18 (a) Funeral director Robt C. B. M. Walton

(b) Address Pratt & Strieker Sts

19 (a) (b) Baltimore, Md.
Registrar

MAR 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 2 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to Mar 26 1946 and that I last saw h[illegible] alive on 3/25 1946

Immediate cause of death Cardiac Decompensation — Duration

Due to Mitral Insufficiency

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas Carlson M.D.

Address 2145 W Balto St Date signed 3/27/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38750
JL - 98603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45D

G38750
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1848 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Dove

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1876

8. AGE: Years	Months	Days	If less than one day
69	11	9	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Charles Dove
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Meeks
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Edward Foulan
(b) Address 2359 Wash Blvd

19 (a) MAR 27 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1946, at 7:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16, 1946, to Mar. 24 1946, and that I last saw h im alive on Mar. 24 1946

Immediate cause of death
1 Pneumonia, Lobar, Rt. Middle & Lower Lobes — 5 days
Due to
Carcinoma, Left Alveolar — Indefinite
Due to Anemia with Metastasis — Indefinite
Arteriolar Nephrosclerosis — Indefinite
Other Conditions Bilateral — Indefinite

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ruth E. Butterworth M. D.
Address Balt. City Hosp. Date signed 3-25-46

X

G38751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G38751 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Juneway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Juneway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA KOCH

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex 7

5. Color or race White

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife Charles Koch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1861

8. AGE: Years 84 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Frisch
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Brag
15. Birthplace Germany

16 (a) Informant Miss Margaret Power
(b) Address 517 N. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick av.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 MAR 27 1946 Washington 25, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to Mar 25 1946 and that I last saw her alive on Mar 25 1946.

Immediate cause of death: Metastasis to Lung
Due to: Carcinoma of Large Bowel
Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H B Haden M.D.
Address 3402 Edwards Date signed 3/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No. C38752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3722 W. Garrison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W/P
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 W. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Umbach

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: J. Henry Umbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1857

8. AGE: Years 88 | Months 8 | Days 0 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Custer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretta Heideman
15. Birthplace Germany

16 (a) Informant Mrs. Edward Farrell
(b) Address 3722 W. Garrison Ave

17 (a) Burial (b) Date thereof 3-27-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Lazzaro Bros
(b) Address 5005 Park Heights Ave

MAR 27 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946 at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5, 1945 to March 25 1946 and that I last saw her alive on March 24 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abel L. Engelwald M.D.
Address 1613 E. North Ave. Date signed 3-26-46

VS 150

X

G38753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38753 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 St Paul Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Margaret Finnegan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Lawrence Finnegan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1914

8. AGE: Years	Months	Days	If less than one day
32	11	27	x hr. x min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name EDWARD ADELSPERGER
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margt Ft MERSON
15. Birthplace Baltimore

16 (a) Informant Lawrence J Finnegan
(b) Address 2108 St. Paul Street

17 (a) Burial (b) Date thereof Mar 28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director Edmondson & Sparrow
(b) Address 3615-17 Edmondson Ave

MAR 27 1946 (b) Huntington Williams Mgr.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1946 to Mar 25 1946, and that I last saw her alive on Mar 25 1946.

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Schlosinger M. D.
Address Union Memorial Hosp Date signed 3/25/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G387:54

AR-97286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G387:54

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 12 Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-12- 1892

8. AGE: Years 53 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William (D)

13. Birthplace Md.

MOTHER 14. Maiden Name Martha Douglas

15. Birthplace Pa.

16 (a) Informant Baltimor City Hospitals Records

(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-46 (month) (day) (year)

(c) Cemetery or crematory Lacedale

Location Germantown Pike

18 (a) Funeral director J. Fahey Lowe

(b) Address 13 Eager St

19 (a) MAR 27 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946, at 7.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1945, to 3-17- 1946, and that I last saw her alive on 3-17- 1946.

Immediate cause of death:	Duration
Cardiac Failure	
Due to Hypertensive Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. P. Jernigan M. D.

Address Baltimore City Hall Date signed 3-26-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

G38755 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt. City
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Gilmore St #17
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Chase (Graham)

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1918

8. AGE: Years	Months	Days	If less than one day
28	-	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Graham
13. Birthplace Md.

MOTHER
14. Maiden Name Mary —
15. Birthplace Md.

16 (a) Informant William Chase
(b) Address 923 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory White Hall,
Location White Hall Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 (a) MAR 27 1946 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1946 at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3-1946 to 3-25-1946 and that I last saw h.e.r alive on 3-25 1946.

Immediate cause of death: Abscess of Liver — Duration

Due to: Abscess of Lung

Due to: of lower lobe,

Other Conditions: rt. lung

(Include pregnancy within 3 months of death)

Date of operation 3-13-46

Major findings of operation: as above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Holbrook M. D.
Address Univ. Hosp. Date signed 3-26-46

G38756 BALTIMORE CITY HEALTH DEPARTMENT G38756

CERTIFICATE OF DEATH 1250 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 E. Randall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 E. Randall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Eberlein

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William F. Eberlein
6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): July 10, 1887

8. AGE: Years 58 | Months 8 | Days 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Henry Schmidt
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Anna Wright
15. Birthplace: Baltimore, Md.

16 (a) Informant: William F. Eberlein
(b) Address: 16 E. Randall St. (Husband)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 27, 1946 (month) (day) (year)
(c) Cemetery or crematory: London Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director: P. Howard Evans
(b) Address: 1400 S. Charles St. (Undertaker or Manager)

19 (a) [illegible] (b) [illegible] Registrar

MAR 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1946 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1946 to March 24 1946 and that I last saw h[illegible] alive on March 23 1946

Immediate cause of death: Acute Yellow Atrophy of Liver

Due to: Chronic Interstitial Nephritis & Edema

Due to: —

Other Conditions: Hypostatic Congestion

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
under
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

Signature: J. H. Darby
Address: 711 Medical Arts Bldg. Date signed: 3/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-98141 6337-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1208 6337-47

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 27days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-1895

8. AGE: Years	Months	Days	If less than one day
51	2	0	hr. min.

9. Birthplace Md., Balto.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER 12. Name Michael Miller (D
13. Birthplace Md.

MOTHER 14. Maiden Name Jennie Hartman (D
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof March 28, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto
18 (a) Funeral director A. Howard Evans
(b) Address 1710 E Chase St (30)
19 (a) (b)
(Date received by registrar) (Registrar)

MAR 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946, at 4.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1945, to 3-25 1946, and that I last saw him alive on 3-25- 1946

Immediate cause of death	Duration
Chronic ulcerative colitis	2 yrs.
Due to	
Due to	
Other Conditions Pernicious Thrombocytopenic Purpura	1 mth.

(Include pregnancy within 3 months of death)

Date of operation Jan 23, 1946
Major findings of operation: Chronic ulcerative colitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henderson W. Phillips M. D.
Address Baltimore City Hosp. Date signed 3-26-46

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1646

Registered No. 638758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days) About 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 Lamont St
(If rural give location)
(e) Citizen of foreign country? ~ (Yes or No)
If yes, name country ~

3 (a) FULL NAME Eugene HUDSON Stack

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 217-18-0858

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife ~

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) January 26, 1922

8. AGE: Years	Months	Days	If less than one day
24	1	29	..... hr. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Receiving Clerk

11. Industry or business Amer. Stores, Inc. Warehouse

FATHER
12. Name Edward J Strack
13. Birthplace Balto., Md

MOTHER
14. Maiden Name Emma Abey
15. Birthplace Balto., Md

16 (a) Informant Edward J Strack (Father)
(b) Address 303 E. Lorraine ave., Balto 18, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Balto. Natl.
Location Balto. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Charles St (Mortician for Williams)

19 (a) (Date rec'd by Registrar) MAR 27 1946 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH (3/25) 1946, at 12 (20) M

21. I certify that I took charge of the remains described above, held an Inquest from Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/25/46 at about 12 Noon M.
(b) Where did injury occur? 1743 Lamont St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Self inflicted gunshot wound

23. Signature C. L. Pulaski M.D.
Medical Examiner.
Date signed 3/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 638759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 S. WOLFE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 S. WOLFE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES SCHOEMBS (JAMES)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: HENRY SCHOEMBS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 9 1861

8. AGE: Years 84 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name BERNARD JACOBS
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant HENRY SCHOEMBS (SON)
(b) Address 724 S. WOLFE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 29/46 (month) (day) (year)
(c) Cemetery or crematory TRINITY
Location ODONNELL ST.

18 (a) Funeral director Lilly & Galeone
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 27 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 26 1946, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to March 26 1946 and that I last saw him alive on March 25 1946.

Immediate cause of death: Cerebral Cardio-Respiratory Failure — Duration: Days

Due to: Chr. Myocarditis — Duration: ?

Due to: Chr. Arterio Sclerosis — Duration: ?

Other Conditions: Parkinson's Disease — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac J. Stanley M.D.

Address 1001 E. Fayette Date signed 3/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38760 JR Casey

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Maddox

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife William C. Maddox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1862

8. AGE: Years	Months	Days	If less than one day
83	4	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business At home

FATHER
12. Name Ned Haried
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ogle
15. Birthplace Md.

16 (a) Informant Malinda Stewart
(b) Address 931 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Williamson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) MAR 27 1946 (b) Registrar of Vital Statistics

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 2:30 PM 3/26/46

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to March 26 1946 and that I last saw h[illegible] alive on March 26 1946

Immediate cause of death: Arteriosclerotic Cardio Vascular Disease

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 933 Fayette St
Date signed 3/27/46

G38761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G38761 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA STS.
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 S. MONASTERY AVE.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM WILLIAM GICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife IDA M. GICK
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) MARCH 15, 1904

8. AGE: Years	Months	Days	If less than one day
41 42	~	9	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation BAKER FOREMAN
11. Industry or business RICE BREAD CO.

FATHER
12. Name JOHN GICK
13. Birthplace GERMANY

MOTHER
14. Maiden Name JOHANNE ZWANZEGI ?
15. Birthplace GERMANY

16 (a) Informant IDA M. GICK
(b) Address 45 S. MONASTERY AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director A. B. Wisbert & Son
(b) Address 1300 Eutaw Place

19 (a) Filed by (b) Huntington Williams, M.D. Registrar
MAR 27 1946

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 24 1946, at 10:02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1946 to 3/24 1946, and that I last saw him alive on 3/24 1946

Immediate cause of death SHOCK — Duration

Due to

Due to

Other Conditions Possible coronary occlusion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hedrick M. D.
Address Mercy Hospital Date signed 3/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

638762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 Parkview Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Years

9 W

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Parkview Terrace
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME: James Edward Codd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary Duke
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1894

8. AGE: Years	Months	Days	If less than one day
52	2	12	--hr. ---min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Manufacturer Mill
11. Industry or business: Supplies

FATHER
12. Name: William C. Codd
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Irma Mohler
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. James Edward Codd
(b) Address: 2806 Parkview Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: Wm. U. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) [illegible] (Signature) Registrar

MAR 27 19[illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1946; at 6 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 19[illegible] to 3/26 1946; and that I last saw h[illegible] alive on 3/26/46 19[illegible]

Immediate cause of death: Coronary Thrombosis — Duration: 30 min

Due to: Carcinoma of Pancreas — years

Due to: Hypotension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: George L. Bailey M. D.
Residence or Office Address: [illegible] Date signed: 3/27/46

X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. 638763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 732 North Haward Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Frederick Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Brown
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs. Payne
(b) Address 604 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances H. Hensley
(b) Address 517 W. Biddle St.

19 MAR 27 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/46 19 , at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner.)
Date signed 3/25/46

G38764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 A

Registered No. G38764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 149 S. Monastery Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 149 S. Monastery Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mary Ellen Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George G. Bell
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1869

8. AGE: Years	Months	Days	If less than one day
76	6 5	9	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name John McCarthy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Custy
15. Birthplace Ireland

16 (a) Informant Mrs. Frank L. Holbein
(b) Address 149 S. Monastery Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) Filed 27 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946 at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1945, to March 25 1946, and that I last saw h[illegible] alive on March 25 1946

Immediate cause of death
Uremia of long standing — Duration ½ hr
Due to Coronary Thrombosis — 3 yrs
Due to Generalized Arteriosclerosis
Other Conditions Old Age

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Mears M. D.
Address 46 Bolton St. Date signed 3-27-46

X=

G38765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G38765 Registered No.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Colorado Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Colorado Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Minnie R. Scanlin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Edwin Eugene Scanlin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 5-1879
8. AGE: Years 67 | Months 1 | Days 11 | If less than one day hr. min.
9. Birthplace St. Michaels Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joshua Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Cheers
15. Birthplace Maryland

16 (a) Informant Edwin Eugene Scanlin
(b) Address 624 Colorado Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (c) MAR 27 1946 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26-1946 at 7:20 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Mar. 26 1946, and that I last saw her alive on March 25 1946

Immediate cause of death: Acute Heart Failure — Duration 2 hours
Due to: Hypertension Heart Disease — 2 years
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature H. Gibson Foote M. D.
Address 4622 Roland Ave Date signed 3/27/46

VS 150

M. D. B 1268-9

G38766

HEALTH DEPARTMENT—CITY OF BALTIMORE

G38766

CERTIFICATE OF DEATH 931

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Cator Ave St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME William Franklin Cannon

(a) Residence: No. 716 Cator St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	widowed

5a. If married, widowed, or divorced HUSBAND of (or WIFE of) Ida Chapman Cannon

6. DATE OF BIRTH (month, day, year) May 19 1861

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	0	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Oct. 1936

11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (city or town) (State or country) Barnesville Delaware

FATHER

13. NAME William Cannon

14. BIRTHPLACE (city or town) (State or country) unknown Delaware

MOTHER

15. MAIDEN NAME unknown

16. BIRTHPLACE (city or town) (State or country) unknown

17. INFORMANT Russell Cannon
(Address) 716 Cator St. Baltimore

18. BURIAL, CREMATION, OR REMOVAL
Place Denton, Md. Date 30 Mar 1946

19. UNDERTAKER J. Virgil Emerson Son
(Address) Denton, Md.

DATE MAR 27 1946 F. Worthington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 27 Mar. 1946

22. I HEREBY CERTIFY, That I attended deceased from 2 Jan. 46, 1946 to 27 Mar 1946

I last saw HIM alive on 26 Mar, 1946. Death is said to have occurred on the date stated above, at 5:30 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	
Arteriosclerosis	

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signed) Lloyd E. Saylor M. D.

(Address) 3982 Greenmount Ave. Balto 18

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G38767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38767 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2648 Mulberry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2648 Mulberry (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary E Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Thomas A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1892

8. AGE: Years	Months	Days	If less than one day
54		20	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John T McSorley
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary McGinty
15. Birthplace Ireland

16 (a) Informant Robt Jordan
(b) Address 2648 Mulberry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto Md

18 (a) Funeral director Geo A Tinley
(b) Address Baltimore, Md

MAR 27 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Mar 1946, and that I last saw her alive on Mar 19 1946

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Pound M. D.
Address 3325 Frederick Av Date signed 3/27/46

VS 150

G38768

485581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G38768 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Marys
(c) City or town California
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Carleton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-23-37

8. AGE: Years 8 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Luther Carleton
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ridgell
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22 1946 (month) (day) (year)

(c) Cemetery or crematory Wolfe Fairbs
Location Great Mills, Md

18 (a) Funeral director W. C. Mattingly & Sons
(b) Address Leonardtown, Md

19 (a) 3/2/1946 (Date rec'd by Local Registrar) (b) Registrar

MAR 27 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 19 1946, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1945 to March 19 1946, and that I last saw him alive on March 19 1946.

Immediate cause of death: Aspiration Pneumonia — Duration 1 day
Due to: Epilepsy — Duration Life
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Blair Everett Batson, M.D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 3/19/46

G38769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38769
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Mohawk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Mohawk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 065-09-8213

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sophie E. Smith
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) February 28, 1893

8. AGE: Years	Months	Days	If less than one day
53	-	29	hr. min.

9. Birthplace New York City, N. Y.
(Town, county, and state)
10. Usual Occupation Production Manager
11. Industry or business Balmar Corp

FATHER
12. Name John Smith
13. Birthplace England

MOTHER
14. Maiden Name Annie Williams
15. Birthplace Ireland

16 (a) Informant Mrs. Sophie E. Smith
(b) Address 3602 Mohawk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30 1946 (month) (day) (year)
(c) Cemetery or crematory Fair View
Location Bergen Co. N.J.

18 (a) Funeral director Willis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) 3 27 [illegible] Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946, at 3.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1946, to 3-27 1946 and that I last saw him alive on 3-27 1946.

Immediate cause of death Coronary Thrombosis — Duration 3 days

Due to Old Atypical Syphilitic Aortitis

Due to Hypertension Cardio Vas Disease

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4509 Liberty Hts. Av Date signed

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G38770 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore – 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Old Frederick Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Duffy (Michael J. Duffy)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Catherine M. Duffy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1859

8. AGE: Years 86 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Salesman Grocery

11. Industry or business Retired

FATHER 12. Name Unknown

13. Birthplace Ireland

MOTHER 14. Maiden Name Unknown

15. Birthplace Ireland

16 (a) Informant William J. Duffy

(b) Address 438 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director George L. Fehrer

(b) Address 1201 Frederick Avenue

(c) (Date rec'd by registrar) MAR 28 1946 (d) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1946, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1946, to 3/26 1946, and that I last saw him alive on 3/26 1946.

Immediate cause of death Coronary failure — Duration

Due to Coronary Thrombosis

Due to Arterio sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Reuett Jr. M.D.

Address 25 Agnes Hosp Date signed 3/26/46

VS 150

G38771

G38771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1278

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address St Jos. Hosp.

(c) Hospital or institution: CAROLINE + OLIVER. 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da

(e) Length of stay in Baltimore (yrs., mos., or days) 1yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town 1601 GREEN MOUNT AVE

(If outside city or town limits, write RURAL and give town)

(d) Street No. Balto MD

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** ETHEL M. CHAFIN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife AUBREY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/95

8. AGE: Years	Months	Days	If less than one day
50	6	19	hr. min.

9. Birthplace Williamson W Va

(Town, county, and state)

10. Usual Occupation Hspa.

11. Industry or business

FATHER

12. Name Robert Clinton Boston

13. Birthplace Va

MOTHER

14. Maiden Name

15. Birthplace Susan C Roop Va

16 (a) Informant Aubrey Chafin

(b) Address 2601 Freemont Ave Balto Md

17 (a) Burial (b) Date thereof 3-29-1946

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Christiansburg Va

18 (a) Funeral director Mary M. Medefield

(b) Address 501 E. 22nd St

19 (a) MAR 28 1946 (b) Huntington Mills Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-1946, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1946, to 3-26 1946 and that I last saw her alive on 3-26 1946

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to TOXIC HEPATITIS	
Due to CIRRHOSIS OF LIVER.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Glen B. Wells M.D.

Address St Jos Hosp Date signed 3-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G38772

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reduced Grism
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Ridgely St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E Prince Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie L Prince
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1904

8. AGE: Years	Months	Days	If less than one day
41	8	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Edward H. Prince
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Kaufman
15. Birthplace Balto. Md.

16 (a) Informant Marie L. Prince
(b) Address 1107 Ridgely St

17 (a) Burial (b) Date thereof 3/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received MAR 28 1946 (b) Registrar Washington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1946 to 3-27 1946, and that I last saw him alive on 3-27 1946

Immediate cause of death	Duration
Coronary thrombosis	
Embolism.	
Due to Mitral obstruction & insuff & aortic obstruction & insuff.	
Due to Rheumatism	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George R. Callender M. D.
Address Univ. Hosp. Balto. Date signed 3-27-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 90B

Registered No. G38713

G38713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 St. Paul St.
(c) Hospital or institution Bon Sec. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba Co Dem Jus 3
(If outside city or town limits, write RURAL and give county)
(d) Street No. 255 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd R. Catlett Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 26th 1944

8. AGE: Years 1 | Months 6 | Days 1 | If less than one day ___ hr. ___ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Lloyd R. Catlett Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Adell LeDuc
15. Birthplace Balto. Md.

16 (a) Informant Lloyd R. Catlett Sr.
(b) Address 255 E. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by Registrar) MAR 28 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1946 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1946 to 19__, and that I last saw h. alive on 3-27 1946

Immediate cause of death	Duration
Pericardial effusion	
Due to Acute pericarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D. LBC4
Date signed 3/27/46

X

G38774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1192 Registered No. G38774

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene 15
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Mt Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Eagle ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 13, 1946

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Philip T Eagle
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Betty Small
15. Birthplace Baltimore Md

16 (a) Informant Philip Eagle
(b) Address 2905 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Funeral Home Williamsport Md

MAR 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1946, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1946, to 3-27 1946, and that I last saw her alive on 3-27 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Gastro-enteritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1946 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Osmund Wisner
Address University Hosp Date signed 3/27/46

G38775 G38775

440622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James George

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) 9-27-10

8. AGE: Years	Months	Days	If less than one day
35	6	-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Edmon George
13. Birthplace Md

MOTHER
14. Maiden Name Edith Wyatt
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30 1946 (month) (day) (year)
(c) Cemetery or crematory Morelands Memorial Park
Location Loughton Ave

18 (a) Funeral director Leo G. Leonard
(b) Address 1201-05 N. Patterson Park Ave

19 (a) (Date received by registrar) (b) Registrar

MAR 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946, at 12.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1946 to March 27 1946 and that I last saw him alive on March 27 1946.

Immediate cause of death	Duration
PHARYNGEAL DIPHTHERIA	4 DAYS
DIPHTHERITIC MYOCARDITIS	2 DAYS
Due to COMPLETE HEART BLOCK	1 DAY
? SECONDARY INFECTION BY	3 DAYS
Due to ? B-HEM STREP WITH CELLULITIS OF NECK	

Other Conditions TRACHEOTOMY.
(Include pregnancy within 3 months of death)
Date of operation 3-26-46
Major findings of operation: COMPLETE LARYNGEAL OBSTRUCTION
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Stephens M. D.
Address Johns Hopkins Hosp. Date signed 3-27-46

Huntington Hallowell, M.D.

G38776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G38776 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 N. Collington ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kneavell

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ wife Laura

6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) Nov 13- 1862

8. AGE: Years	Months	Days	If less than one day
83	4	14	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Matthew Kneavell
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Charles Kneavell (Son)
(b) Address 522 N. Collington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore County Md

18 (a) Funeral director George A. Weber
(b) Address 705 So. Linn st Huntington Williams Mgr.

19 (a) [illegible] (b) [illegible]

MAR 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to March 27 1946
and that I last saw h~~im~~er alive on March 27 1946

Immediate cause of death	Duration
Coma - va Cvd	acute
Bronchopneumonia	
Due to Chr Myocarditis, Endocarditis	?
Due to Chr Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary F. Douglas M.D.
Address 700 N. Patterson Pk Date signed 3/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G38777 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 868 Pierce Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 868 Pierce Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA WALKER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 70 | Months 76 | Days | If less than one day hr. min.

9. Birthplace Charles Co., Md. (Town, county, and state)

10. Usual Occupation Seamtress

11. Industry or business

FATHER
12. Name Austin Swan
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Miss Evelyn Gray
(b) Address 2203 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-46 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b) Registrar

MAR 28 1946

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 26, 1946 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1946 to March 26 1946, and that I last saw Deceased alive on March 24 1946.

Immediate cause of death Carcinoma of Left Breast — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey M.D.

Address 1928 Penna Ave Date signed 3/27/46

X

G38778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G38778

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Edgewood Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3404 Edgewood Road.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD MAKOVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Rose S. Makover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1869.

8. AGE: Years	Months	Days	If less than one day
76	5	5	hr. min.

9. Birthplace Poland,
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Aaron J. Makover,
13. Birthplace Poland,

MOTHER
14. Maiden Name Unknown,
15. Birthplace Poland.

16 (a) Informant Mr. A. B. Makover,
(b) Address Balto. Trust Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3.28.46. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.
(c) [illegible]

MAR 28 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27th. 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1945, to Mch-27 1946, and that I last saw h[illegible] alive on Mch-27-1946.

Immediate cause of death Cardiac failure — Duration about 20-30 years

Due to Myocardial Insuff:

Due to Coronary disease

Other Conditions Chronic-Pulmonary T.B. & cholecystitis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Herman Seidel M. D.
Address 2404 Eutaw Place. Date signed 3-27-46

942

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

G38779 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 N. Carey St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elsie Williams White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1912

8. AGE: Years	Months	Days	If less than one day
44	2	-	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Louis Williams
13. Birthplace Q. A. Co. Md.

MOTHER
14. Maiden Name Louise Phillips
15. Birthplace Kent Co. Md.

16 (a) Informant Louise Williams
(b) Address 513 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28, 1956 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 323 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 28 1956 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-46 19 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22/46 19, and that I last saw her alive on 3/22/46

Immediate cause of death
(a) Appendicitis — Duration 2 days
Due to Hypertension
Due to
Other conditions Pneumonia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elsie Barksdale M.D.
Address 524 E. Lexington St. Date signed 3/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

G38780 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Glendale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Glendale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Piessol Cussy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Bessie P. Cussy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1859

8. AGE: Years	Months	Days	If less than one day
87	.	24	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Retired Pen RR

FATHER
12. Name John Cussy
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sarah Piessol
15. Birthplace Baltimore Md

16 (a) Informant Eva Cussy
(b) Address 3109 Glendale Ave

17 (a) Burial (b) Date thereof 3/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Vernon M. E. Cem
Location White Hall Md

18. (a) Funeral director John C. Nolan
(b) Address 3000 E Baltimore St

19 (a) MAR 28 1946 (b) Registrar Huntingtown, Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26th 1946, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945, to March 26 1946, and that I last saw h[illegible] alive on March 26 1946.

Immediate cause of death	Duration
Far advanced arteriosclerotic cardiovascular renal disease	10 yrs
Due to arthritis, chronic, left knee	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify trade or place)
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed M. 3/27/46 D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X over 46 E

Registered No. G38781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 29da

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Talbot
(c) City or town EASTON
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME MAUDE (illegible) BLAIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ROBERT H. BLAIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-1888

8. AGE: Years 58 | Months 2 | Days 18/19 | If less than one day ... hr. ... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name Robert Symons
13. Birthplace England

MOTHER
14. Maiden Name Susan Saddley
15. Birthplace England

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md.

18 (a) Funeral director John F Denny Inc
(b) Address 718 Eight St

19 (a) [illegible] (b) [illegible] Huntington Williamsport Md

MAR 28 1946

VS 150

MEDICAL CERTIFICATION 1946

20. DATE OF DEATH 3-28 1946, at 3:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1946, to 3-28 1946, and that I last saw her alive on 3-27 1946.

Immediate cause of death: Carcinomatosis & metastasis — Duration

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation 2-28-46

Major findings of operation: Inoperable carcinoma of stomach & metas.

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence March 28 at ... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place; in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Gayle J Arnold M. D.
Address Talbot Date signed 3-31-

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G38782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Harview Ave
(c) Hospital or institution: *****
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Harview Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Strawbridge

3 (b) If veteran, name war ****
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife I Harry Strawbridge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1866

8. AGE: Years 79 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Andrew Shannon
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name ****** Blakney
15. Birthplace Baltimore Md

16 (a) Informant Roland Strawbridge (Son)
(b) Address 2908 Harview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 29 / 46 (month) (day) (year)
(c) Cemetery or crematory Louden Park Cemetery
Location Frederick Rd Baltimore Md.

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave. Baltimore Md

19 (a) (Date received by registrar) MAR 28 1946 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 3.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1942 to March 26 1946 and that I last saw her alive on March 25 1946.

Immediate cause of death: Hypertensive arteriosclerotic Heart disease — Duration 15 years
Due to chronic myocarditis (failure)
Due to
Other Condition Carcinoma of cervix Generalized debility (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. V. Harbold M. D.
Address 4706 Harford Road Date signed 3/29/46

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G38783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Nelson Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4402 Belle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carole Lynn Pumphrey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: fe

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 13/1946

8. AGE: Years | Months: 1 | Days: 13 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name A Gorman Pumphrey
13. Birthplace Anne Arundel Co Md

MOTHER
14. Maiden Name Jean Elizabeth Pumphrey
15. Birthplace Baltimore Md

16 (a) Informant A. Gorman Pumphrey
(b) Address 4402 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry N Armacost
(b) Address 4204 Pickwood Ave

19 Filed MAR 28 1946 by Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946 at 6 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13th 1946, to March 28 1946, and that I last saw h.e.r. alive on March 2 19

Immediate cause of death	Duration
Respiratory failure	
Due to Congenital heart	
Due to	
Other Conditions Idiocy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia, atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Smalley M.D.

Address Maryland Ellipse Date signed 3/28/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G38784 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 336 Sargeant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 336 Sargeant St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John T. Adams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Lula Laura A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 16 1879

8. AGE: Years 67 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name John T. Adams
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura R. Craig
15. Birthplace Maryland

16 (a) Informant Mr. Geo J. O'Neal
(b) Address 336 Sargeant St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3800 Frederick Ave

18 (a) Funeral director John Cowan & Son
(b) Address 406-03 Hollins St.

19 (a) MAR 28 1946 (b) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 11 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1946 to March 16 1946, and that I last saw h. l. M alive on March 16 1946

Immediate cause of death: Carcinoma of Prostate gland — Duration 3 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature John B. Uelink, Jr M. D.
Address 1222 Wash. Blvd Date signed March 27 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G38785 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norval George

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1945

8. AGE: Years	Months	Days	If less than one day
	2	27 29	hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Georges
13. Birthplace Athens Greece

MOTHER
14. Maiden Name Rose Sanderes
15. Birthplace Baltimore Md

16 (a) Informant Mr James Georges
(b) Address 1110 Scott St

17 (a) Burial (b) Date thereof 3/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Edmondson Ave

18 (a) Funeral director Colin Campbell
(b) Address 1411-13 Pulton St

19 (a) MAR 28 1946 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1946, to 3-27 1946
and that I last saw him alive on 3-27 1946

	Duration
Immediate cause of death Resp. failure	
Due to Pneumonia	24 hrs
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Armand Wiener M.D.
Address Univ. Hosp. Date signed 3/31/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G38786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 Wyman Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Wyman Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JULIUS DUBBELDE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothea Dubbelde
6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1869

8. AGE: Years 77 | Months 1 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business: Real Estate

FATHER
12. Name: Julius J. Dubbelde
13. Birthplace: Germany

MOTHER
14. Maiden Name: Lena Smit
15. Birthplace: Germany

16 (a) Informant: Mrs. Dorothea Dubbelde
(b) Address: 2916 Wyman Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(Address) NORTH AVE. & BROADWAY

19 MAR 28 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 6. A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1945 to 3-26 1946 and that I last saw him alive on 3-25 1946

Immediate cause of death	Duration
Cerebral hemorrhage	2 hr.
Due to Arteriosclerosis	5 y.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard L. Warren M. D.
Address 2604 Garrison Blvd Date signed 3-26-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

638787 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1635 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 N Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bennett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Clarence E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/1891

8. AGE: Years 04 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris Robinson
13. Birthplace S. C.

MOTHER 14. Maiden Name Ida Small
15. Birthplace S. C.

16 (a) Informant Clarence E. Bennett
(b) Address 1635 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location MD

18 (a) Funeral director Geo. G. Kelso
(b) Address 1303 Freedman St

19 (a) (Date rec'd by Reg.) MAR 28 1946

VS 1 Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1945 to March 26 1946 and that I last saw h— alive on March 25 1946.

Immediate cause of death Uremia

Due to Renal Failure

Due to Cardio-Renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayland D. Jones M.D.
Address 1302 N. Fremont Ave Date signed 3/28/46

G38788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1701 C

G38788

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. Lake St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert G. Jury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie Hollstein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1887

8. AGE: Years	Months	Days	If less than one day, hr.	min.
68 ~~95~~	4	7		1877

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Architect
11. Industry or business

FATHER
12. Name John G. Jury
13. Birthplace Bridgeton, New Jersey

MOTHER
14. Maiden Name Margaret Wagner
15. Birthplace Baltimore

16 (a) Informant John G. Jury
(b) Address 5106 Jamestown Rd, Yorktown Village

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-46 (month) (day) (year)
(c) Cemetery or crematory Arlington National Cem.
Location Arlington Virginia

18 (a) Funeral director John J. Mitchell
(b) Address 1900 Eutaw Place

19 MAR 28 1946 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Chest
Ruptured Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 27 1946 8:20 P.M.
(b) Where did injury occur? Yale Ave Auchentoroly Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto

23. Signature Benedict Skiturelis M.D. Medical Examiner.
Date signed 3-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 a

Registered No. G38789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 E. Read St.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. Read St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Spillane Gilpin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Bernard Gilpin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
about 80			hr. min.

9. Birthplace New York State (?)
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Spillane
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Isabella C. Murphy
(b) Address 12 E. Read St.

17 (a) Burial (b) Date thereof 3/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends
Location Harford Rd. & 25th St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1960 Eutaw Place

19 MAR 28 1946 (b) Huntington Wilt.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 3/27 1946 and that I last saw h[illegible] alive on 3/27/1946

Immediate cause of death

Arter. Sclerosis — Duration 4 Yrs

Due to Coronary Thrombosis

Due to Age. 89 Given age by Informt

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Magruder M. D.
Address 14 E. Read St. Date signed 3/28/46

VS 150

19 2689 Hr Mt Vernon 2689 X

G38790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G38790

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 S. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Fenwick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Fenwick Sr.
13. Birthplace Rotterdam

MOTHER
14. Maiden Name Riggle?
15. Birthplace Md.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 3/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Pauls Cem
Location Johns Hopkins Hospital Md. 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 28 1946 Huntington Williams M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1946 to 3-26 1946, and that I last saw him alive on 3-26 1946

	Duration
Immediate cause of death Acute Pulmonary Edema	2d
Due to Coronary Occlusion	2d.
Due to Arteriosclerosis	
C.V.D.	
Other Conditions Varicose ulcers	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Slaughter M.D.
Address Church Home & Hosp Date signed 3-26-46

VS 150

F 3387 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G38791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gorsuch Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Mc Comas St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LULA WHITE BYNUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Fred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26 1895

8. AGE: Years	Months	Days	If less than one day
51 50	0	0	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Charles Bynum
(b) Address 615 Warner Street

17 (a) Removal (b) Date thereof March 29 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rocky Mount N.C.
Location Edgecombe County

18 (a) Funeral director Joseph G. Duffy
(b) Address 400 N. Main Street

19 (Written locally by registrar) MAR 28 1946 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1946 at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 3-26 1946 and that I last saw her alive on 3-26 1946

Immediate cause of death Cardiac failure

	Duration
Due to Toxic nephritis of pregnancy	
Due to Toxic liver & muscles	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene H. Conner M.D.
Address Univ. Hospital Date signed 3-27

VS 150

638792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

638792 Registered No. (over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Cottage City Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3737 Cottage Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Ina B. Lee Wells

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2. 1916

8. AGE: Years	Months	Days	If less than one day
29	6	22 25	hr. min.

9. Birthplace Centreville Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Ernest Wells
13. Birthplace Md

MOTHER
14. Maiden Name Ethel Elbert
15. Birthplace Md

16 (a) Informant Marshall Wells
(b) Address Riverdale Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Ft. Lincoln
Location Bladensburg Rd & E

18 (a) Funeral director W. H. Chambers
(b) Address Riverdale Md

19 (a) Registrar (b) Huntington Williams M.D. Registrar

MAR 28 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/46 19 at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20/46 19 to 3/27/46 19, and that I last saw him alive on 3/27/46 19

Immediate cause of death	Duration
Hemicerebral Hemorrhage	
Due to Contributory factor Tolectomy	
Due to	
Other Conditions Pulmonary Embolism	

(Include pregnancy within 3 months of death)

Date of operation 3/27/46

Major findings of operation: Tuberculosis of upper lobe.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.
Address Bethesda Md. Date signed 3/27/46

G38793 ✓ G38793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 482

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 1918 Madeira St., 2nd Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 14 yrs. mos. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Viola Levy (Levy) Simpson — If U. S. Veteran specify WAR

(a) Residence: No. 1918 Madeira St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fe	col	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) June 11, 1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	2	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Waitress

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) N. C

FATHER

13. NAME William F. Levy

14. BIRTHPLACE (city or town) (State or country) N. C.

MOTHER

15. MAIDEN NAME Dempsie J. Young

16. BIRTHPLACE (city or town) (State or country) N. C.

17. INFORMANT Effie Padgett
(Address) 1713 Madeira Av

18. BURIAL, CREMATION, OR REMOVAL
Place Fayetteville N.C. Date 3-28 1946

19. UNDERTAKER Archibald A. Haddix
(Address) 210 McCulloch St.

20. FILED MAR 28 1946 Huntington Williams, M.D. Registrar.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 26, 1946

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1946 to March 26, 1946. Last saw h[illegible] alive on March 26, 1946. Death is said to have occurred on the date stated above, at 8:30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Cervix	
Other contributory causes of importance:	

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M Kinlaw M.D.

(Address) 803 N Fremont

638794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

638794 Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Joel Seligman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-2675

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated.

6 (b) Name of husband or wife (Separated) Mary Seligman.
6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) July 6 1885

8. AGE: Years	Months	Days	If less than one day
60	8	21	hr. min.

9. Birthplace Balto. Md (town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business

FATHER
12. Name Charles Seligman
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Rose Heinzman
15. Birthplace Balto. Md

16 (a) Informant Miss Lillian Seligman
(b) Address 615 N. 14th St. Milwaukee Wis

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom Cem.
Location O'Donnell St.

18 (a) Funeral director J. Ahrens Co.
(b) Address 2437 Reisterstn Rd.

19 (a) MAR 28 1946 (registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary sclerosis
Cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed March 26 1946.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

638795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registration No. 638795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Sharp St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Galloway

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/92

8. AGE: Years 54 | Months 55 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charlie Green
13. Birthplace Md

MOTHER
14. Maiden Name Mary Gaines
15. Birthplace Md

16 (a) Informant Effie Burley (S)
(b) Address 917 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location G. G. Co Md

18 (a) Funeral director Isaiah L. Bunch & Son
(b) Address 1054 W Montgomery

19 (a) Date received by Registrar MAR 28 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/1946, at 2 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1946 to Mar 25 1946 and that I last saw him alive on Mar 25 1946

Immediate cause of death: Cardio Vascular Disease — Duration: 6 hrs

Due to

Due to

Other Conditions Paralysis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 515 Lexington Date signed 3/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38796 — BALTIMORE CITY HEALTH DEPARTMENT — G38796

CERTIFICATE OF DEATH 45c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Carroll St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry S Tuttborn.
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-01-1942

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Widowed.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1872.

8. AGE: Years	Months	Days	If less than one day
73	8	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Watchman.
11. Industry or business Horstmeier Lumber Co.

FATHER
12. Name William S Tuttborn
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Amelia Stuttborn
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mrs Gladys Cardna.
(b) Address Northwood apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar-29-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Ave.

18 (a) Funeral director Krause Funeral Home.
(b) Address 1216 E Chase St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

vs MAR 28 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/1946 at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 3/26/1946, and that I last saw him alive on 3/26/1946

Immediate cause of death Carcinoma of Cheek (Left)

Duration
1 year

Due to

Due to

Other Conditions Metastasis to tongue—palate.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Nutter M.D. M. D.
Address 122 E Chase St Date signed

X 3/27/46

JL - 1001797 G38797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G38797

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 S. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hulzman (or) John H. Halseman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1888

8. AGE: Years	Months	Days	If less than one day
57	5	3	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn.
Location Eastern Ave

18 (a) Funeral director C. Lehmicrowd
(b) Address 260 E. Madison Street

19 (a) Filed MAR 28 1946 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 27 1946, at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26 1946, to Mar. 27 1946, and that I last saw h im alive on Mar. 27 1946

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Cofland Jr. M.D.
Address Balt. City Hosp. Date signed 3/28/46

(over) X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38798 Hilburn

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38798

CERTIFICATE OF DEATH 1310 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 Harlem Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hilburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Susie Tilghman Hilburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894 Oct. 31.

8. AGE: Years	Months	Days	If less than one day
51	5	26	hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation
11. Industry or business Doctor

FATHER
12. Name James H. Hilburn
13. Birthplace Texas.

MOTHER
14. Maiden Name Maggie
15. Birthplace Texas

16 (a) Informant Susie T. Hilburn
(b) Address 846 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30 '46 (month) (day) (year)
(c) Cemetery or crematory Western Star.
Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 28 1946 (by registrar) (b) Frantington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 9 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1941 to 3/26 1946 and that I last saw h[illegible] alive on 3/25 1946.

Immediate cause of death Cerebral accident

Due to Hypertension Cardiac Cerebral Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 Yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature B. H. Halsey
Address 1 W Mt Royal Ave Date signed 3-28-46

G38799 HEALTH DEPARTMENT—CITY OF BALTIMORE G38799

CERTIFICATE OF DEATH 1310

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 519 Schroeder N St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Clarence Diggs

If U. S. Veteran specify WAR

(a) Residence: No. 519 Schroeder N St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	C.	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha

6. DATE OF BIRTH (month, day, year) 1885 - April 11

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	11	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Samuel Diggs

14. BIRTHPLACE (city or town) (State or country) Balto. Md.

MOTHER

15. MAIDEN NAME Mollie

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Hilda Howard

(Address) 519 N. Schroeder St.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Date March 29, 1946

19. UNDERTAKER Mrs. Katie R. Williams

(Address) 322 N. Schroeder St.

20. FILED MAR 28 1946 Huntington Williams Registrar.

N. B.—WRITE PLAINLY, WITH NON-FADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Mar. 25, 1946

22. I HEREBY CERTIFY, That I attended deceased from March 1, 1946 to March 25, 1946

I last saw him alive on March 25, 1946 Death is said to have occurred on the date stated above, at 8 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic myocarditis	
Other contributory causes of importance:	
Cardio-vas. Renal	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Edward J. Kentlar, M. D.

(Address) 1220 Druid Hill Ave

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638800

CHK-100167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 638800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 86- 8- 7-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT L. RENSHAW

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1859

8. AGE: Years	Months	Days	If less than one day
86	8	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Lemuel Renshaw
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah A. Clark
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Chas. H. Grandt Son Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) [illegible] (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 27- 1946, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1946 to March 27 1946 and that I last saw him alive on March 27 1946

Immediate cause of death Uremia	Duration
Due to Cerebral Thrombosis, C.V.	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber, Jr. M. D.
Address Balt. City Hosp. Date signed 3-28-46

X

G38801

99999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G38801

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5409 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Adam Felbinger

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-6975

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	15	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Sigmon

13. Birthplace Md.

MOTHER 14. Maiden Name Cecelia Meehan

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Location Dempsey Hill Rd.

18 (a) Funeral director John D Connelly

(b) Address 418 Eastern Ave. Towson

19 (Signature) MAR 28 1946 Huntington Williams, M.D. Registrar

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 19 46 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 19 46 to Mar. 26 19 46 and that I last saw h 1m alive on Mar. 26 19 46

Immediate cause of death: Pulmonary Tuberculosis — Duration 2

Due to: Tuberculosis Meningitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr M.D.

Address Balt. City Hosp. Date signed 3/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CNK-100154

G38802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38802

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
75- 5- 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2533 Arunah Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Edmond Behrens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14-1869

8. AGE: Years	Months	Days	If less than one day
76	8	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Henry Behrens
13. Birthplace Germany

MOTHER
14. Maiden Name Mendy ?
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East E. North Ave.

18 (a) Funeral director Edw. Lorman & Son
(b) Address 2413 Pollitt Street

19 (a) (b) Huntington Williams, M.D.
(Date received) MAR 28 1946

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 27 1946, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 19 46 to March 27 19 46, and that I last saw h. 1m alive on March 27 1946

Immediate cause of death Cardiac Failure
due to Uremia

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Auricular Fibrillation, Hydrothorax, Rt., Pericardial Fusion, Rt. Pleural Fusion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A Fairbairn M.D.
M. D.
Address Balt. City Hosp. Date signed 3-28-46

X

G38803

BALTIMORE CITY HEALTH DEPARTMENT

CWK-99087

CERTIFICATE OF DEATH 132

Registered No. G38803

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1m 14-
(e) Length of stay in Baltimore (yrs., mos., or days) 22 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6620 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Looper, Junior

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-24-1082

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2-1907

8. AGE: Years	Months	Days	If less than one day
38	8	18	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Looper
13. Birthplace South Carolina

MOTHER
14. Maiden Name Rossie Johnson
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 28 1946

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 28 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20-1946 19 , at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1946 to March 20 1946, and that I last saw h im alive on March 20 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert L. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 3/26/46

VS 150

3388

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G38804 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Clifton Ave.
(c) Hospital or institution: 15-24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSIE A. BACKMAN

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George P. Backman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 19, 1878

8. AGE: Years	Months	Days	If less than one day
67	11	8	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name -- Roesler
13. Birthplace Germany

MOTHER
14. Maiden Name ---- Neuman
15. Birthplace Germany

16 (a) Informant Mr. George A. Backman
(b) Address 1807 Clifton Ave.

17 (a) Burial (b) Date thereof 3/30/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Meadowridge Cem.
Location Wash. Blvd., Howard Co., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar
(Date rec'd by registrar)

MAR 28 1946

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27- 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1927 to 3-27 1946 and that I last saw h alive on 3-25- 1946

Immediate cause of death Coronary thrombosis — Duration 9 yrs.

Due to Oedema of Lung — 1 day

Due to

Other Conditions Mitral Stenosis — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Seymour Pirosh M. D.

Address 2202 W. North Ave. Signed

Seymour Pirosh

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38805 JL - 100080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G38805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) ~~S~~Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Herr

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Sep.

6 (b) Name of husband or wife Rose Ann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1898

8. AGE: Years	Months	Days	If less than one day
47	9	4	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James O. Herr
13. Birthplace Pa.

MOTHER
14. Maiden Name Florence ? (D)
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 3/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Pa
Location

18 (a) Funeral director Wm. J. Jackson & Son
(b) Address Mount Olivet Cemetery

19 (a) Date received by registrar MAR 28 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1946 19 , at 7.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 22, 1946 to March 23, 1946 and that I last saw h... alive on Mar. 23 1946

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 3/28/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38806 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 15 — Registered G38806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Burnley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-21

8. AGE: Years 24 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace Reedville, Va (Town, county, and state)

10. Usual Occupation Lung Helper

11. Industry or business

FATHER
12. Name Charlie Dunnfey
13. Birthplace Va

MOTHER
14. Maiden Name Susie Jeffries
15. Birthplace White, Va

16 (a) Informant R. White
(b) Address 1504 N. Mount st

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-29-46 (month) (day) (year)
(c) Cemetery or crematory Salem Cem
Location Chase - Virginia

18 (a) Funeral director William E. Jackson
(b) Address 9 E. Penna Ave Huntington, W. Va.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1946, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1946, to 3-26 1946, and that I last saw h[illegible] alive on 3-26 1946

Immediate cause of death: Peritonitis — Duration

Due to: Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature I. B. Higgins / R. White M. D.
Address 1514 Division St Date signed 3-26-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38807 (✓) G38807

BALTIMORE CITY HEALTH DEPARTMENT

HB # 99989 CERTIFICATE OF DEATH 12B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1909

8. AGE: Years	Months	Days	If less than one day
36	10	12	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dock Cook
13. Birthplace Va.

MOTHER
14. Maiden Name Polly Jackson
15. Birthplace Va.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-46 (month) (day) (year)
(c) Cemetery or crematory Lebanon Mem. Pk. Location Baltimore County Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave.

19 (a) (Date rec'd by Registrar) MAR 29 1946 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 27, 1946 at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18, 1946 to March 27 1946, and that I last saw h im alive on March 27, 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr M. D.
Address Balt. City Hosp. Date signed 3/28/46

X

G38803

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38803

CERTIFICATE OF DEATH 1628

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Harwood ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Harwood ave (If rural-give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nannie Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1861

8. AGE: Years 84 | Months 10 | Days 26 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel B Clayton
13. Birthplace maryland

MOTHER
14. Maiden Name Catherine Ernst
15. Birthplace unknown

16 (a) Informant Leona Hurst
(b) Address 506 Harwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Henry W Jenkins Son Co
(b) Address McCulloh Orchard Sts

19 (a) MAR 29 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to March 28 1946, and that I last saw h[illegible] alive on 3/27 1946

Immediate cause of death: Myocardial failure — Duration: 3 days

Due to: old age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clemell Howell M. D.
Address Towson, Md Date signed 3/29/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G38809 ✓ G38809

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 St Paul St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Schroeder Taylor Meehan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Albert Meehan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1866

8. AGE: Years	Months	Days	If less than one day
79	9	18	hr. min.

9. Birthplace Paris France
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Schroeder Taylor
13. Birthplace Md

MOTHER 14. Maiden Name Eliza H Bradlee Winchester
15. Birthplace Boston Mass

16 (a) Informant Henry S Taylor White
(b) Address 39 Warrenton Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30th 1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry V Jenkins Sons
(b) Address 2 Orchard St

MAR 29 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946, at 2:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture
Intracranial Hemorrhage
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 27/1946 M.
(b) Where did injury occur? 710 St. Paul St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall to floor at home
23. Signature Benedict Skotarchic M.D.
Medical Examiner.
Date signed 3-27-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

✓ G38810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 N. Charles St
(c) ~~Hospital or institution~~: Warrington Apts 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura Lanman Riggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or ~~wife~~: Alfred R Riggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1825

8. AGE: Years 71 | Months 2 | Days 20 | If less than one day hr. min. 87

9. Birthplace New York N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Trumbell Lanman
13. Birthplace Norwich Conn.

MOTHER
14. Maiden Name Eliz. Batelle Knapp
15. Birthplace Newburyport Mass

16 (a) Informant Mrs. Henry A Parr III
(b) Address Glyndon Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 29 1946 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Son Co
(b) Address McCulloh & Eutaw Sts

19 (a) (Date rec'd by registrar) MAR 29 1946 (b) Registrar Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 28 1946, at 7:37 A M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 1945, to MAR 28 1946, and that I last saw h~~im~~er alive on MAR 27 1946.

Immediate cause of death	Duration
ARTERIOSCLEROSIS	15 YRS
ESSENTIAL HYPERTENSION	7 YRS
LT. Due to CEREBRAL HEMMORHAGE	1 YR
RT " "	4 DAYS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph G. Hills M. D.
Address 16 E EAGER ST. Date signed MAR 28 46
CALLED ME X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G38811 ✓ Registered No. G38811

G38811 FB # 32038

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9 13
(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jording August

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine (d.)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1873

8. AGE: Years 73 | Months 0 | Days 18 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Charles Jording
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Andrew
15. Birthplace: Germany

16 (a) Informant: Balto. City Hospitals (Records)
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery: West Lawn
Location: Baltimore Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 627 St. Paul St.

19 (a) MAR 29 1946 (Date rec'd by registrar)

Huntington Williams Asst. Baltimore City Health Officer

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 14, 1945 to March 27 1946 and that I last saw h im alive on March 27, 1946

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Carcinoma of lung & Bronchiectasis

Due to:

Other Conditions: Calcified aortic valve
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.

Date signed 3-28-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G38812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 6/4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 S Durham (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William Bowling

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1877

8. AGE: Years 68 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business Laborer

FATHER
12. Name Wm. Bowling
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Snow
15. Birthplace Md

16 (a) Informant Records
(b) Address — Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (Date received by Registrar) MAR 29 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1946, at 3:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1946 to 3/24 1946 and that I last saw h.i.YR alive on 3/24 1946.

Immediate cause of death Cerebral - Vascular accident — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm C Bowling Jr

Address Mercy Date signed 3/24

X

G38813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G38813 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Stony Run Lane
(c) Hospital or institution:
Mc Kenna Memorial Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Gay St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James S. Lowry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Emma L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1874

8. AGE: Years	Months	Days	If less than one day
71	10	22	hr. min.

9. Birthplace Phila Pa
(Town, county, and state)
10. Usual Occupation Immanuel Trohen
11. Industry or business

FATHER
12. Name Albert Wilson Lowry
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Lowry
15. Birthplace Dulond

16 (a) Informant Elizabeth Lowry
(b) Address Atlantic City N.J.
17. Funeral (b) Date thereof 3/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharonville
Location Sharonville Md.
18 (a) Funeral director Wilson & Son
(b) Address 1217 E Cont St.
19 (a) (Date rec'd MAR 29 1946) Registrar Huntington Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelis M.D.
Medical Examiner.
Date signed 3-28-46

VS 151

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G38814 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Harty Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Adolphus Burton
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race N
6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-9-1863
8. AGE: Years 82 Months 10 Days 15 17 If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Malachi Burton
13. Birthplace Va
MOTHER 14. Maiden Name Edmonia
15. Birthplace Va
16 (a) Informant Son
(b) Address 1630 Dunne St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co
18 (a) Funeral director Rayner & Sanders
(b) Address 1402 E Preston St
19 (a) (b)

MAR 29 1946 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1946, at 12 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1946 to 3-26 1946, and that I last saw h[illegible] alive on 3-26 1946.

Immediate cause of death	Duration
Pneumonia	
Due to Gangrene of right foot	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Jackson, /Turnbitt M. D.
Address 1514 Division St Date signed 3-26-46

G38815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38815 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 E. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto. (b) County
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jamer Leicht

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-6063

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife: Mary Leicht

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Philipp Leicht
13. Birthplace Penna

MOTHER 14. Maiden Name Henriretta Shaffer
15. Birthplace Penna

16 (a) Informant Mary Leicht
(b) Address 2406 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30th 1946 (month) (day) (year)
(c) Cemetery or crematory Evangelical Lutheran
Location Sherwood Spring Pa.

18 (a) Funeral director Leo G. Leo Sr.
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Signature of local registrar) (b) Williams, M.D. Registrar

MAR 29 1946

Hastings for

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27th 1946, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1946 to 3/27/1946 and that I last saw h/ alive on 3/27/1946

Immediate cause of death Coronary Thrombosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mathias F. Hunsicker M. D.

Address 1016 S. Ellwood Ave Date signed 3/29/46

X

G38816 | BALTIMORE CITY HEALTH DEPARTMENT | G38816

CERTIFICATE OF DEATH 181

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Mapleton & Erdman (Shack) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Starkey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Carrie Starkey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7-1894

8. AGE: Years	Months	Days	If less than one day
150 ~~51~~	5	20	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Starkey
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Rankin
(b) Address 3610 Mt. Pleasant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd.

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St.

19 (a) (b) Registrar

Date received by registrar MAR 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946 at 11 A. M

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-15-46 at 2:30 P.M.
(b) Where did injury occur (Shack) Mapleton & Erdman Avenues
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Burned by bonfire

23. Signature Robert Lee Statham M.D.
Medical Examiner.
Date signed March 27 1946

X 471

G38817

HB # 99525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 13

G38817

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Joseph Antkowiak

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2544

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1909

8. AGE: Years	Months	Days	If less than one day
37	1	27	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Antkowiak (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida Nitka
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-30-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) MAR 29 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946 at 6:P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 1946, to March 27, 46 and that I last saw h 1m alive on March 27 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr M. D.
Address Balt. City Hosp. Date signed 3/29/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G38818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 39 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Foster ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS PIETROZYSKA Thomas Pietruszka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Ludwinka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacub Pietruszka
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs Karolina Rostek Daughter
(b) Address 316 S. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - 1 46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (Date received by local registrar) MAR 29 (b) 1946

Huntington Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1946 to 3/27 1946, and that I last saw him alive on 3/27 1946.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Thrombophlebitis	
Due to Post operative — herniaplasty	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Hamburger M.D.
Address Sinai Hospital Date signed 3/27/46

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38819 ✓ G38819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3303 E. Baltimore St.
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Morganweck

3 (b) If veteran, name war	3 (c) Social Security Account No.
66—	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude Morganweck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1872

8. AGE: Years	Months	Days	If less than one day
74 76	1	24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Dairyman (retired)
11. Industry or business

FATHER
12. Name Martin Morganweck
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide --
15. Birthplace Germany

16 (a) Informant Mrs. Gertrude Morganweck
(b) Address 3303 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) Date rec'd by registrar MAR 29 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 26, 1946, at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1 1941 to MAR. 26 1946. and that I last saw h IN alive on MAR 26 1946.

Immediate cause of death	Duration
ATROPHIC SCLEROSIS	
Due to LIVER	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature allen E Southam, M. D.
Address 3139 E. Belvedere Ave Date signed March 29-46

X Beetham 28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G38820
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 S Conkling St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Conkling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Reese

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Caroline Reese
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Jan 8 - 1879

8. AGE: Years	Months	Days	If less than one day
67	2	24	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Meat Dealer
11. Industry or business

FATHER
12. Name Martin J. Reese
13. Birthplace Baltimore

MOTHER
14. Maiden Name Katherine Voltz
15. Birthplace Baltimore

16 (a) Informant Martin J. Reese
(b) Address 1624 S Ponca Road

17 (a) Burial (b) Date thereof March 31
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Lulsick Funeral Home
(b) Address 2008 Orleans St

19 MAR 29 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27th 1946, at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3-45 to 3-27-46 19..., and that I last saw h— alive on 3-26-46 19...

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Arteriosclerotic cardiovascular disease

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Constantine M.D.

Address 234 S Conkling St Date signed 3-28-46

VS 150

37123
G38821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G38821 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ledella Johnson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bradley Johnson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-24-94
8. AGE: Years 51 | Months 8 | Days 2 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business
12. Name of Father: Charles Downs
13. Birthplace of Father: Md.
14. Maiden Name of Mother: Annie Perry
15. Birthplace of Mother: Md.
16 (a) Informant: Friends
(b) Address: JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/46 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem'l. Pk
Location: Balto. County, Md.
18 (a) Funeral director: Charles G. Cooper
(b) Address: 512 N. Carrollton Ave
19 (a) MAR 29 1946 (Month, day, year) Waiting for Medical Cert

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24, 1946 at 9:20 M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1946 to Mar. 24 1946 and that I last saw him alive on Mar. 24 1946
Immediate cause of death: Cardiac failure — Duration
Due to: Hypertension & Renal disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Philip A. Turnbull
Address: Johns Hopkins Hosp. (Date signed)

VS 150

Dr. Grenzer
1402 E. Lanvale St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G38822

The G38822

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 Rosalie Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Rosalie Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-03-2943

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lillian C. Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1885

8. AGE: Years	Months	Days	If less than one day
61	1	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name Jacob Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Fischer
15. Birthplace Md.

16 (a) Informant Mrs. Lillian C. Schmidt
(b) Address 2909 Rosalie Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 MAR 29 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th, 1946 at 7:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1939 to March 28 1946 and that I last saw him alive on Mar. 27 1946.

Immediate cause of death Coronary thrombosis — Duration 36 hrs

Due to

Due to

Other Conditions Cerebral thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Grenzer M.D.
Address 1402 E. Lanvale St. Date signed 3.28.46.

VS 150

G38823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G38823 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Raspeburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5809 Farmview
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Foreman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward F Foreman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/92

8. AGE: Years	Months	Days	If less than one day
53	3	6	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Prokop Pernica
13. Birthplace Bohemia

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr Edw F Foreman
(b) Address 5809 Farmview Ave

17 (a) Burial (b) Date thereof 3/30/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location E North Ave Baltimore, Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) MAR 29 1946 Huntingtown Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28 1946 at 7.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1946, to 3-28 1946, and that I last saw h-e-r alive on 3-28 1946

Immediate cause of death Medical shock — Duration

Due to Diabetic coma

Due to acidosis

Other Conditions Lobar pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L D Mace M. D.
Address Univ. Hospital Date signed 3-28

VS 150

DoA accident room
Med 638824
Released to Undertaker.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓ Registered No. G38824

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 E Madison St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Madison Ave St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alonza M Dorman

3 (b) If veteran, name war: Yes No I
3 (c) Social Security Account No. 219-03-7239

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ethel Dorman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1896

8. AGE: Years 49 | Months 5 | Days | If less than one day: hr. min.

9. Birthplace Cambridge Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER: 12. Name Spread Dorman
13. Birthplace Cambridge Md
MOTHER: 14. Maiden Name Martha Hooper
15. Birthplace Cambridge Md

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A Co Md
18 (a) Funeral director Robert Williams
(b) Address 1545 McElderry St
19 (a) (Date received by Registrar) (b) MAR 29 1946 Registrar

VS 150

MEDICAL CERTIFICATION 95

20. DATE OF DEATH March 27 1946 at 2 a M
21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1946 to March 27 1946 and that I last saw h[illegible] alive on 19
Immediate cause of death Probably pulmonary edema — Duration: Unk.
Due to Undetermined cause, probable heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lola B. Medway
Address Johns Hopkins Date signed 3/29/46

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

Registered No. G38825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Linden ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Masten

3 (b) If veteran, name war	3 (c) Social Security Account No.
	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Major Masten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11, 1879

8. AGE: Years	Months	Days	If less than one day
66	7	14	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Chas. Masten
(b) Address 946 W. Lanvale St.

17 (a) Burial (b) Date thereof 3/29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Presbyterian
Location 5900 York Road

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 MAR 29 1946 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-1946, at 5-50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra cerebral Hemorrhage

Due to

Other Conditions Bronchio-pneumonia, Emaciation and tuberculosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 12-22-45 at 1.45 P.M.
(b) Where did injury occur? Linden Ave. & Laurens St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by street car

23. Signature Howard J. Thelen M.D.
Medical Examiner.
Date signed 3-26-46

Huntington Williams, MD

X 426

G38826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G38826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 Charles Road
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 106 Charles Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Helen Richardson Bowie

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Clarence
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1883

8. AGE: Years 62 | Months 4 | Days 13 | If less than one day - hr. - min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Wm. G. Richardson
13. Birthplace Alexandria Va.

MOTHER
14. Maiden Name Emma A. Williams
15. Birthplace Accomac Co. Va.

16 (a) Informant C. H. Bowie Jr. - Son
(b) Address 106 Charles Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore.

18 (a) Funeral director Shivers Mooney Co
(b) Address 102 W Monroe St

19 MAR 29 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 27 1946, at 1.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1945 to Mar 27 1946 and that I last saw h[illegible] alive on Mar 27 1946

Immediate cause of death: Exhaustion, Nephritis & Cachexia

Duration
due to Meta static Carcinoma of Liver, peritoneal cavity & lungs - from Dec. 31, -
Antecedent: Carcinoma Right Breast - May 1944.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Stoddard M. D.
2925 N Charles St Date Mar 46

VS 150

G38827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38827 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2314 South Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 South Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMIL R. KREILING

3 (b) If veteran, name war --
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth S. Hesse Kreiling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/1870

8. AGE: Years	Months	Days	If less than one day
75	3	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Grocery
11. Industry or business Self

FATHER
12. Name August Kreiling
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Fred J. Kreiling
(b) Address 5603 Everhurst Rd.

17 (a) Burial (b) Date thereof 3/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Pikesville, Md.

19 (a) MAR 29 1946 (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to March 27 1946. and that I last saw h[illegible] alive on March 25 1946.

Immediate cause of death	Duration
1) Arterio-Sclerotic Heart Disease	5 yrs. ?
Due to	
Due to	
Other Conditions - Prostatectomy - Diabetes -	1 yr.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl L. Chambers, M.D.
Address 4108 Liberty Hts. Date signed 3/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 940 G38828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2216 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. SANDERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-09-8171

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Carlotta C. Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1882

8. AGE: Years	Months	Days	If less than one day
64	0	1	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Joseph W. Sanders
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Laura C. Smith
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Carlotta C. Sanders
(b) Address 2216 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory LORRAINE MAUSOLEUM
Location Woodlawn Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 29 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 27, 1946, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1944 to 3-27 1946, and that I last saw him alive on 3-26 1946.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions General arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2424 Brighton St Date signed 3-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G38829 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 W. University Parkway
(c) Hospital or institution:
none 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. University Pky.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jean W. Lowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Allan Bennett Lowe
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1907

8. AGE: Years	Months	Days	If less than one day
38	5	21	hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name David J. Walters
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Jane H. Walters
15. Birthplace England

16 (a) Informant Mrs. Lemuel Miller
(b) Address Cape May, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)
(c) Cemetery or crematory Cold Spring
Location Cape May, N. J.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Williams, Mgr. Registrar

MAR 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1946, at 1045 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28-1945 to March 28 1946, and that I last saw her alive on March 24 1946

Immediate cause of death: Exhaustion — Duration

Due to Carcinoma of lungs

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Gibson Porter
Address 4822 Roland Ave. Date signed 3/29/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G38830

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington (b) County
(c) City or town Seattle (If outside city or town limits, write RURAL and give town)
(d) Street No. "Regent Hotel" (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Arnold, Robert Daniel, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 558-16-9479

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Edith Williams
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	21	hr. min.

9. Birthplace Delliart, Texas (Town, county, and state)
10. Usual Occupation Chief Cook
11. Industry or business seafarer

FATHER
12. Name Robert Daniel Arnold
13. Birthplace ? Texas

MOTHER
14. Maiden Name Lizzie Mc Gowan
15. Birthplace Ontario, Canada

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Crematory
Location York Rd.

18 (a) Funeral director Odell Funeral Home Inc.
(b) Address 4644 York Rd.

19 (a) (Date received by Registrar) MAR 29 1946 Livingston Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24 1946 at 3:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16 1946 to Mar. 24 1946 and that I last saw him alive on Mar. 24 1946.

Immediate cause of death	Duration
Coronary sclerosis with occlusion.	Unknown
Due to	
Myocardial infarction left ventricle, old	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 3/28/46
US Marine Hospital, Balto, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 W. Camden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 W. Camden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Augusteen Defina

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dominic Defina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1878.

8. AGE: Years 68 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Catanzaro
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. Wm. E. Gilbert
(b) Address 4 N. Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Kutzke
(b) Address 4101 Edmondson Ave.

19 (a) Filed (registrar) Huntington Williams M.D.

MAR 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 3.45a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1945 to Mar 27 1946 and that I last saw h[er] alive on Mar 26 1946.

Immediate cause of death: Hypertensive Cardiovascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration: years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Zoppe

Address 3101 N. Baltimore Ave. Date signed 3/28/46 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G38832
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 Hillen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Keenan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Not obtainable

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------- 1874

8. AGE: Years	Months	Days	If less than one day
72	----	---	--hr. ---min.

9. Birthplace New York State
(Town, county, and state)

10. Usual Occupation Hospital Orderly

11. Industry or business -------

FATHER
12. Name Not obtainable
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant H. W. Mears & Son
(b) Address 805 N. Calvert Street

17 (a) Burial (b) Date thereof 3/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 29 1946 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946, at 10:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed 3-27-46

C38833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

C38833 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place.
(c) Hospital or institution: Ellinger Nursing Home. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Eutaw Place.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA M. ROLLER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Maurice Roller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1865.

8. AGE: Years	Months	Days	If less than one day
81	2	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wolf Meyenberg,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sarah Bernheimer,
15. Birthplace Conn.

16 (a) Informant Mrs. Julius Kemper,
(b) Address 5400 Tansy Road.

17 (a) Burial (b) Date thereof 3. 31. 46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Baltimore, Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) Filed by registrar Huntington Williams, M.D. Registrar

MAR 29 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th, 1946, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 3/28 1946, and that I last saw h alive on 19.

Immediate cause of death	Duration
Cardeac foilure	10 days
Due to arteris-sclerosis	5 yrs.
Cerebral Hemorhage (hemiplegia)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Leitz M. D.
Address Temple Garden Apts. Date signed 3/29/46.

X

C38834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

C38834 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4440 Clydesdale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4440 Clydesdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie or Rosie Patti

3 (b) If veteran, name war None
3 (c) Social Security Account No. none

4. Sex Fem.
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jacob Patti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29 1882

8. AGE 63 Years | Months 2 | Days 27 29 | If less than one day hr. min.

9. Birthplace Vallelolmo Italy
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Joseph Chely
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Polline
15. Birthplace Italy

16 (a) Informant Jacob Patti (Husband)
(b) Address 4440 Clydesdale Ave

17 (a) Burial (b) Date thereof 3/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Walsh Sons
(b) Address 52 N. Morley St.

19 (a) MAR 29 1946 (b) Huntington Williams M.D.
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1946 to Mar 27 1946 and that I last saw h[illegible] alive on Mar. 26 1946

Immediate cause of death Cachexia — Duration
Due to Carcinomatosis
Due to Carcinoma of Rectum
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw. F. Glassman M. D.
Address 7037 Falls Rd. Date signed 3/28/46

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38835 — BALTIMORE CITY HEALTH DEPARTMENT — C38835

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 Plowman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Plowman
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Michael Vogel

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-07-3884

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Vogel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 16 1882

8. AGE: Years	Months	Days	If less than one day
64	1	11	hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Railroad Buy Operated
11. Industry or business: Wolbert Body Co.

FATHER
12. Name: Louis Vogel
13. Birthplace: Germany

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Anna Vogel (Wife)
(b) Address: 811 Plowman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30 1946 (month) (day) (year)
(c) Cemetery Mt. Carmel
Location O'Donnel St.

18 (a) Funeral director: Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1946

VS 1M

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to 3/27/46 19 and that I last saw h alive on 3/27/46 19

Immediate cause of death: General Tuberculosis Pelvis Chronic Myocarditis — Duration: 3 yrs. 3 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Milton L. Solomon
Address 129 E. Broadway Date signed 3/27/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

C38836 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Kutler St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Kutler St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Easie Carter Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Richard Brown
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1904

8. AGE: Years 42 | Months | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? King
13. Birthplace Calvert Co Md.

MOTHER 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Richard Brown
(b) Address 1424 Kutler St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co. Md

18 (a) Funeral director William J. Chatman
(b) Address 1701 McCulloh St.

19 (a) ... (Date rec'd by registrar) Washington Williams, M.D. registrar

MAR 29 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1946, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 - 1943 to Mar. 27, 1946, and that I last saw h. sl. alive on Mar. 14, 1946

Immediate cause of death Cardiac Arrest — Duration 3½ years

Due to Chronic Myocarditis

Due to /

Other Conditions /

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: /

of autopsy: /

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Garnefeld M. D.
Address 1881 Eutaw Pl. Date signed 3/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G38837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 N. Wolfe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Gough

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Sally
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-95

8. AGE: Years	Months	Days	If less than one day
51	1	16	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Tom Gough
13. Birthplace Va

MOTHER
14. Maiden Name Eliza Future
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert C. Elliott
(b) Address 1629 N. Carlisle St.

MAR 29 1946 (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946, 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 11 1946 to Mar 27 1946, and that I last saw h alive on Mar 22 1946.

Immediate cause of death	Duration
[illegible] Cerebral hemorrhage	
Due to ? [illegible] Hypertensive cardiovascular disease	
Due to Arteriosclerotic nephritis	
Other Conditions Uremia.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Austin M. D.
Address Johns Hopkins Hosp. Date signed 3/28/46

C38838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

C38838
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The cause and age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 Mt. Olivet Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 334 Mt. Olivet Lane
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Arthur Carroll Davis

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna Marie Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Paperhanger
11. Industry or business Self

FATHER
12. Name Chester Davis
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Saffran
15. Birthplace Maryland

16 (a) Informant Anna Marie Davis
(b) Address 334 Mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director Lizzie L. Schwab
(b) Address 2101 Frederick Avenue

MAR 29 1946 (Date received) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1946, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from November 1945, to March 28 1946, and that I last saw him alive on March 28 1946

Immediate cause of death: Coronary Heart disease — Duration: 10 Mos

Due to —

Due to —

Other Conditions: Pneumonia — 14 hr

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Harrell Price M. D.

Address 312 Med. Arts Bldg Balto. Md Date signed 3/29/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

C38839
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 N Thomas Ave
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 N Thomas Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. McCabe

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Katie Margaret McCabe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 1858

8. AGE: Years 57 | Months 9 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Tool & Die Maker
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Herman R. McCabe
(b) Address 1706 Thomas Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George L. Ehrhart
(b) Address 2101 Frederick Avenue

19 (a) MAR 29 1946 (Date received) (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946, at 6:18 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1946 to 3/27 1946, and that I last saw h[illegible] alive on 3/27 1946.

Immediate cause of death	Duration
Pericarditis ? Vascular Failure	3/27
Due to Lobar Pneumonia	3/23
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Roach
Address 3629 Edgendale Date signed 3/27/46 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

C38840 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4106 St. Thomas Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27+
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 St Thomas Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Lansdale Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edith Mae Jackson

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1898

8. AGE: Years 48 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Prince George Co., Md.
(Town, county, and state)

10. Usual Occupation Car Repairman RR Co.

11. Industry or business

FATHER 12. Name Henry Jackson
13. Birthplace Prince George Co. Md.

MOTHER 14. Maiden Name Elena Shoemaker
15. Birthplace Prince George Co. Md.

16 (a) Informant La Vere Agresch
(b) Address 4106 St Thomas Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/46 (month) (day) (year)

(c) Cemetery or crematory St. Mary's Hampden
Location Roland ave

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) (b) Washington, D.C.

MAR 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1946, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/44 1946, to 3/28 1946, and that I last saw him alive on 3/24 1946.

Immediate cause of death Toxemia, myocardial insufficiency. — Duration 1 day.

Due to Carcinoma prostate with metastatic carcinoma

Due to of bone, liver, chest — 1 Year?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/3/46

Major findings of operation: Metastatic carcinoma of right humerus

of autopsy: NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold C. Gillsberg M. D.

Address 31 E. North Avenue Date signed 3/29/46

X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2869 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2869 Woodbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES F. BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1875

8. AGE: Years	Months	Days	If less than one day
70	4	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James F. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name -- Taylor
15. Birthplace Md.

16 (a) Informant Mr. Frank H. Brown,
(b) Address 11 Howard Ave., Catonsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 30 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 28, 1946, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/27/46 to 3/28/46, and that I last saw h[im] alive on 3/27/46

Immediate cause of death: Cystic Kidney + Acute Uremia — Duration: Sudden
Due to: Chronic Nephritis + Complications of Preg. — Duration: Years
Due to — Duration: Months
Due to — Duration: Days
Other Conditions

(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellen C Howard
Address 432 W Mount Ave. Date signed 3/28/46

C38842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

Registered No. C38842

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Chelsea Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Chelsea. Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA E. WALKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widower

6 (b) Name of husband or wife Augustus I. Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1869

8. AGE: Years	Months	Days	If less than one day
76	9	20	hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business Self

FATHER
12. Name John D. Boyer
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name -- Brandenborg
15. Birthplace Frederick Co., Md.

16 (a) Informant Mrs. Hazel W. Anthony
(b) Address 3017 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 30 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28, 1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Mch 27 1946 and that I last saw h[illegible] alive on Mch 27 1946.

Immediate cause of death — Duration

Carcinoma of uterus & — 8 yrs.
Due to fulminating pneumonia.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Bowman Lord M. D.
Address 2200 Garrison Blvd Date signed 3/29/46

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C38843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Winterbourne Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Winterbourne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM A. ROBINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1879

8. AGE: Years	Months	Days	If less than one day
66	8	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew Robinson
13. Birthplace Ireland

MOTHER
14. Maiden Name Isabel White
15. Birthplace Ireland

16 (a) Informant Mrs. John K. Robinson
(b) Address 3305 Winterbourne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 30 1946 (Date rec'd by Registrar) (b) Huntington Nathanson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1946 at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 1946 to March 28, 1946 and that I last saw h[illegible] alive on 3-28-1946

Immediate cause of death	Duration
Circulatory failure	3 days
Due to Coronary Thrombosis	30 days
Due to Previous coronary thrombosis	1 yr.
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer M. D.
Address 3300 W. Mulberry St. Date signed 3/29/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

638844 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D.O.A.
(b) Street address
(c) Hospital or institution: West Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore C.T.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Brighton St
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed,~~ or ~~divorced~~.
F	W	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 - 1850

8. AGE: Years	Months	Days	If less than one day
95	6	23	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Brown
13. Birthplace Balto Md

MOTHER
14. Maiden Name Not Known
15. Birthplace Balto Md

16 (a) Informant Mrs Reba Coplin
(b) Address 3038 Brighton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/46 (month) (day) (year)

(c) Cemetery or crematory Baldwin Mem Church
Location Westminster Md

18 (a) Funeral director Geo H Leimbach
(b) Address 1711 N Lyndhurst St.

19 (a) (b) (Signature of registrar) Huntington Williams, M.D.

MAR 30 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1946, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V. disease

Due to

Other Conditions Arteriosclerotic C.V. disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature E. L. Sulinski M.D.
Medical Examiner.

Date signed 3/29/46

X

G38845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G38845 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 S. STREEPER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. STREEPER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HERBERT E. ZITZER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: FANNIE ZITZER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 23 1880

8. AGE: Years 65 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation LITHOGRAPHER

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant HERBERT L. ZITZER (SON)
(b) Address 613 S. STREEPER ST.

17 (a) BURIAL (b) Date thereof APR 21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHEY HIGHWAY

18 (a) Funeral director Lilly & Ziler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (b)
(Date rec'd by registrar) (Signature of Registrar)

MAR 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 28 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1946, to 28 Mar 1946 and that I last saw h[illegible] alive on Mar 1 1946

Immediate cause of death	Duration
Coronary thrombosis	1 hr.
Due to arteriosclerosis	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeDoux M. D.
Address 601 S. Edward Ave. Date signed 3/30 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38846 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6209 Blackburn Lane
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6209 Blackburn Lane
(If rural give location)
(e) Citizen of foreign country no (Yes or No)
If yes, name country

3 (a) FULL NAME James Edwin Triplett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Maud Wissler
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1878

8. AGE: Years 68 | Months 2 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation accountant

11. Industry or business

FATHER
12. Name William H. Triplett
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Templeman
15. Birthplace Va.

16 (a) Informant William H. Triplett
(b) Address 6629 Hillendale Road, Chevy Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 MAR 30 1946 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Mar. 28 1946 and that I last saw him alive on 3/28 1946.

Immediate cause of death: Coronary Thrombosis — Duration 1 hr.
Due to Arterio-sclerosis Myocarditis — Duration Indefinite
Due to ...
Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature W W Woody
Address 1403 Park Ave. Date signed 3/29/46 M.D.

Dr. Woody X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38847 — BALTIMORE CITY HEALTH DEPARTMENT — C38847 (Registered No.)

CERTIFICATE OF DEATH 127a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loudon & Fredrick Ave.
(c) Hospital or institution: Md. General Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Rigg Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Fonwood

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 May - 1862

8. AGE: Years	Months	Days	If less than one day
83	10	26	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Fonwood
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Sarah Coan
15. Birthplace Balto - Md

16 (a) Informant Anthony Fonwood
(b) Address 2800 Rigg Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 1 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Fredericks Ave.

18 (a) Funeral director John O. Albertis
(b) Address 1900 Eutaw Place

19 (a) MAR 30 1946 (Date received by registrar) Huntington Hospital, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Mar. 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Mar. 1946, to 29 Mar. 1946, and that I last saw h.i.m. alive on 29 Mar. 1946.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Failure occurred during Trans urethral resection of prostate	
Due to	
Other Conditions Prostatic hypertrophy	

(Include pregnancy within 3 months of death)
Date of operation 29 Mar - 46
Major findings of operation: Hypertrophy of prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Smith M. D.
Address Md. Gen. Hosp. Date signed 3/29/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 a

Registered No. C38868

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Hospital 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ella A. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1869

8. AGE: Years	Months	Days	If less than one day
77	1	5	hr. min.

9. Birthplace Preston, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Edwin E. Atkinson
13. Birthplace Preston, Md.

MOTHER
14. Maiden Name Elizabeth E. Kelley
15. Birthplace Preston, Md.

16 (a) Informant Records, Southern Home
(b) Address 2510 Greenmount Ave.

17 (a) Burial (b) Date thereof 4/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 MAR 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 27. 1946. to Mch. 28 1946. and that I last saw h[illegible] alive on Mch. 28. 1946.

Immediate cause of death	Duration
Chronic Interstitial	
Due to Nephritis.	1 yr
Due to Acute Cardiac Dilatation	2 da.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Herbert A. Blake M. D.
Address Medical Arts Bldg. Date signed

Dr. Herbert A. Blake X

G38849
AB-97200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1218

G38849
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos- 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Peter Fero

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15- 1889

8. AGE: Years 56 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Fero
13. Birthplace Austria

MOTHER
14. Maiden Name Mary ?
15. Birthplace Austria

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Druid Hill
Location Druid Hill Park

18 (a) Funeral director Taylor Funeral Home
(b) Address 1318 Pennsylvania Ave.

19 (a) (Signature of local registrar) (b) Registrar

MAR 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24- 1946, at 6AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1945 to 3-24 1946 and that I last saw him alive on 3-24- 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp Date signed 3-28-46

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure the correct age is especially important.

C38850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C38850

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5014 Gwynn Oak Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5014 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John M. Merritt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Florence A. Merritt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 18, 1877

8. AGE: Years	Months	Days	If less than one day
69	-	10	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: U. S. Civil Service

FATHER
12. Name: B. S. Merritt
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Margaret Bell
15. Birthplace: Ireland

16 (a) Informant: Mrs. Herbert J. Mahle
(b) Address: 5014 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cemetery
Location: Woodlawn, Md.

18 (a) Funeral director: Phillips Lawrence
(b) Address: 4510 Liberty Heights Ave.

19 (Registrar) MAR 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946, at 9 P. M

21. I certify that death occurred on the date above stated, and I attended deceased from 3/20/46 to 3/28/46.
and that I last saw him alive on 3/26/46.

Immediate cause of death: Coronary occlusion

Due to: Arterio Sclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:

of autopsy: None

Duration: ? Few minutes 5 yrs & more knowledge

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: H. W. Harper M. D.
Address: 5201 Gwynn Oak Ave Date signed

Huntington for Williams, M.D.

G38851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38851

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 695 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 695 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Agnes Waters

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1889

8. AGE: Years 56 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Cornish

13. Birthplace Maryland

MOTHER 14. Maiden Name Fanhjie Davis

15. Birthplace Maryland

16 (a) Informant Albert Waters

(b) Address 695 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave

MAR 30 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 56

20. DATE OF DEATH March 27, 1946 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1946 to March 27 1946 and that I last saw h[illegible] alive on March 27 1946

Immediate cause of death: Carcinoma of breast — Duration 6 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address 1500 Eutaw Place Date signed March 30 1946

VS 150

G38852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38852 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered or "None" or "Unknown" where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Jackson Street
(c) Hospital or institution: 24-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Jackson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLEN M. BANGS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/1870

8. AGE: Years	Months	Days	If less than one day
75	5	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name William Abbott
13. Birthplace Maryland

MOTHER 14. Maiden Name Henrietta Collison
15. Birthplace Maryland

16 (a) Informant Family
(b) Address 1510 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director James L. McCully
(b) Address 130 S. Fort Ave.

19 MAR 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946, to March 28 1946, and that I last saw h[illegible] alive on March 27 1946.

Immediate cause of death Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions Cystoscopic Examination & Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Schwenck M. D.
Address 1337 E. Chase St. Date signed 3/29/46

X

G38853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G38853

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 E. Oldham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Junior Hlatky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 29th 1946

8. AGE: Years | Months | Days | If less than one day 18 hr. 10 min.

9. Birthplace Maryland Gen. Hospital
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Joseph Hlatky

13. Birthplace Vulcan Pennsylvania

MOTHER 14. Maiden Name Vera Greco Hlatky

15. Birthplace Farrell Pennsylvania

16 (a) Informant Joseph Hlatky

(b) Address 615 E. Oldham St. Balto 24

17 (a) Burial (b) Date thereof 3-30-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director Frank Della Noce

(b) Address 52 N. Morley St.

19. (a) MAR 30 [illegible] Registrar

Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29 1946 at 10 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 29 1946 to Mar. 29 1946 and that I last saw h[illegible] alive on Mar. 29 1946

Immediate cause of death	Duration
Atelectasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Noguera M.D.

Address Maryland General Hospital Signed

X

G38854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G38854 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Lakewood Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Lakewood. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Beatty

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James L. Beatty

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) June 13-1880

8. AGE: Years 65 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John. Buettner
13. Birthplace Germany

MOTHER
14. Maiden Name M. Brutking
15. Birthplace Germany

16 (a) Informant Geraldine Beatty
(b) Address 119 N. Lakewood Av

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3/30/46 (month) (day) (year)

(c) Cemetery or crematory Holy Red.
Location Belair Rd

18 (a) Funeral director John. A. Mahan
(b) Address 3000 E. Balto St

19 (a) (Date received) **(b)** Registrar

MAR 30 1946 Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/46 19 , at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1940 to March 28 1946, and that I last saw h[illegible] alive on 3/27 1946.

Immediate cause of death Hypostatic pneumonia
Bronchopneumonia

Duration 2

Due to

Due to

Other Conditions Broncho pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter J. Sikorsky M. D.

Address 5939 Dr. Pleasant **Date signed** 3/30/46

G38855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38855 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 Eutaw a.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Eutaw a (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael J. Dean

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes L.

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.): Sept. 6 1868

8. AGE: Years 77 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace: Balto Md. (Town, county, and state)

10. Usual Occupation:
11. Industry or business: Ret. Fire Deptt.

FATHER
12. Name: George A. Dean
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Elizabeth
15. Birthplace: Balto Md.

16 (a) Informant: Agnes L. Dean
(b) Address: 800 Eutaw a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/46 (month) (day) (year)
(c) Cemetery or crematory: New Balto.
Location: Old Frederick Rd

18 (a) Funeral director: John A. Hagan
(b) Address: 3000 E. Balto. St

19 (a) (Date received by local registrar) (b) MAR 30 1948 Huntington, W. Va.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1946 to March 28 1946 and that I last saw h[illegible] alive on March 29 1946

Immediate cause of death: Coronary Thrombosis — Duration: 7 weeks

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Wm D Schultz M. D.
Address: 701 N. Kenwood Ave. Date signed: 3/29/46

G38856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G38856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 22

(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 654 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John T. Boyle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary A. Divinney

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 19[illegible] 1877

8. AGE: Years	Months	Days	If less than one day
68	11	10	..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired Boiler-Maker

11. Industry or business

FATHER
12. Name Michael Boyle
13. Birthplace Md

MOTHER
14. Maiden Name Jane Cosgrove
15. Birthplace Md

16 (a) Informant Mr. John T. Boyle
(b) Address 1929 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Balto. Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

MAR 30 1946 (Date rec'd by Registrar)

19 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946, at 5:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial Hemorrhage

Due to Contusion & laceration of brain

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/2

(a) Date of injury February 11, 1946
(b) Where did injury occur? In front of 654 Wash. Blvd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fall on street

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-29-46

VS 151

G38857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G38857

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RACHEL HILLIARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Michael F. Hilliard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1881

8. AGE: Years	Months	Days	If less than one day
64	11	29	hr. min.

9. Birthplace Norway
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Lund
13. Birthplace Norway

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Michael F. Hilliard
(b) Address 2500 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/1946 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER &S ONS
(b) Address Balto., Md.

MAR 30 1946 (Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 28 1946, at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1945 to Mar 25 1946.
and that I last saw her alive on Mar 25 1946.

Immediate cause of death: Anemia & starvation — Duration

Due to Cancer of Gall Bladder — Duration

Due to Cuetastasis to liver — Duration

Other Conditions Hypop of Gall Bladder & drainage of Bile. — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of Gall Bladder

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd Date signed 3-29-46

G38858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G38858 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun Street
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Symington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Eugene L. Belli

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Elsie L. Belli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1885

8. AGE: Years	Months	Days	If less than one day
61	2	13	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Restaurant Owner
11. Industry or business

FATHER
12. Name Anthony Belli
13. Birthplace Italy

MOTHER
14. Maiden Name Jennie Porta
15. Birthplace Italy

16 (a) Informant Mrs. Elsie L. Belli
(b) Address 108 N. Symington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address 30 1946 Balto., Md.

19 (a) MAR (Date rec'd by registrar) (b) Huntington for Baltimore, Md.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946 at 7:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26 1946 to Mar 29 1946 and that I last saw him alive on MAR. 29 1946

Immediate cause of death: Hemorrhage from bladder — Duration
Due to: Hypertrophy prostrate
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hogan M. D.
Address Date signed

John A. Hogan

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G38859 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 N. Stakton St
(c) Hospital or institution: —

L6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 N. Stockton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mary Colee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Horace Colee

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1882

8. AGE: Years 63 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Wilmington, Del.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home

FATHER
12. Name Howard Stokes
13. Birthplace Pa.

MOTHER
14. Maiden Name Fannie Howell
15. Birthplace Del.

16 (a) Informant Alfred D. Holley (Son)
(b) Address 1104 N. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 1, 1946 (month) (day) (year)

(c) Cemetery or crematory Marion Cemetery
Location Bucks Co. Pa.

18 (a) Funeral director John M. Dohnson
(b) Address 17 S. Dru[illegible] Baltimore

19 (a) [illegible] (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to March 27 1946 and that I last saw h[illegible] alive on March 25 1946

Immediate cause of death: Carcinoma Liver — Duration: Probably 12 Mos.

Due to —

Due to —

Other Conditions Metastasis To Lungs — 6 mos

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph T. Young M. D.

Address 1424 E. Monument Date signed 3/29 1946

G38860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1486

G38860 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1235 Wall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 Wall St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Krempler

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry M. Krempler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 - 1868

8. AGE: Years	Months	Days	If less than one day
77	8	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Bailey
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Fardin
15. Birthplace Maryland

16 (a) Informant Mrs. M. Zeller
(b) Address 1235 Wall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1-1946 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial
Location Ritchie Highway G.A. Co.

18 (a) Funeral director Elizabeth Earle Inc.
(b) Address 116 E. West St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 30 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/46, 1946, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 45 to 19 ; and that I last saw him alive on 3/27 19 46.

Immediate cause of death	Duration
Pathological fracture of Right hip	Dec 1945
Due to Metastasis - carcinoma of	
Other Conditions uterus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1211 St. Paul Date signed 3/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38861
AB-92731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G38861
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr- 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 46yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21-1880 ?

8. AGE: Years 65? Months 7 Days 6 If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nelson Fisher
13. Birthplace Va.

MOTHER
14. Maiden Name Alice ?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

MAR 30 1946
(Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27- 1946, at 6.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23- 1945 to 3-27- 1946 and that I last saw him alive on 3-27- 1946

Immediate cause of death: Bronchopneumonia — Duration:

Due to: Carcinoma of Colon

Due to: Hypertensive Cardiovascular Disease

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hall Date signed 3-29-46

X

G38862

CWZ-99708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

305

G38862

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and complete the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 Days
51- 2- 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Exeter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Elizabeth Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Henry Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4-1895

8. AGE: Years	Months	Days	If less than one day
51	2	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Gaines (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ellis (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1020 Broadway ave

19 MAR 30 1946 (b) Huntington Williams, M.D.
(Signature of registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 27 1946, at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1946 to March 27 1946, and that I last saw h er alive on March 27 1946.

Immediate cause of death Bronchopneumonia — Duration

Due to Luetic Ht. Disease E Aortic Insuff. + Congestive Failure

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Farber, Prof. M. D.
Address Balt. City Hosp. Date signed 3-28-46

VS 150

G38863 G38863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1926

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 N. Dallas st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) **FULL NAME** Isaac Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1899

8. AGE: Years 46 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace White Stone, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Taylor
13. Birthplace Va

MOTHER 14. Maiden Name Sallie Campbell
15. Birthplace Va

16 (a) Informant Harriet Taylor
(b) Address 1302 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/26 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Belvedere and

MAR 30 1946
(Date received by Registrar)

(b) Physician Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1926, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1926 to March 27 1926, and that I last saw him alive on March 26 1926.

Immediate cause of death	Duration
a Cause Respiratory failure.	
Due to Pulmonary edema	3 days
Due to Valvular heart disease	1 month
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. C. Burwell M. D.
Address 171 Craigville Date signed 3-29-26

G38864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38864 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Strangspring & Belvidere Aves
(c) Hospital or institution: Lewindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Lewindale (If outside city or town limits, write RURAL and give town)
(d) Street No. Formerly 910 Eastbank (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA BRENNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Israel Louis Schneider
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Schneider
15. Birthplace Russia

16 (a) Informant Lion Brenner
(b) Address 3916 Barenor Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Hebrew Rus
Location Bowley's Lane

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W Madison

MAR 31 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30- 1946 at 8 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1939 to 3-30 1946 and that I last saw her alive on 3-30 1946

Immediate cause of death Hypertension Cardiovascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hedwig d. Kevin Md.
Address Lewindale Date signed 3-30-46 M.D.

VS 180

G38865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G38865 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Payson St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Collecton, Abraham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Madeline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1898

8. AGE: Years 47 | Months 8 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Saleswoman

11. Industry or business

FATHER 12. Name David Collecton
13. Birthplace Russia

MOTHER 14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Madeline Collector
(b) Address 1821 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31 1946 (month) (day) (year)
(c) Cemetery or crematory Helen Mt Carmel Cem Co
Location German Hill Road

18 (a) Funeral director Sol Levinson Bro.
(b) Address 1124-26 W Northave

19 (a) ____ (Date rec'd by registrar) Huntington Williams M.D. Registrar

MAR 31 1946

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH March 30 1946, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 1946 to Mar 30 1946 and that I last saw h in alive on Mar 30 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral metastasis	
Due to Carcinoma of lung	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-31-46
Major findings of operation: Carcinoma of lt. lung.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Bennett M. D.
Address Church Home & Hosp. Date signed 3/30/46

VE 150

4750X

G38866 BALTIMORE CITY HEALTH DEPARTMENT G38866
CERTIFICATE OF DEATH 1937 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Rhuley Ave
(c) Hospital or institution: Mt. Carmel Hems
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE BETTIGOLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Asher -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation H. W
11. Industry or business

FATHER 12. Name Elliott -
13. Birthplace R.

MOTHER 14. Maiden Name Lloyd -
15. Birthplace R.

16 (a) Informant Minnie Ph
(b) Address 4702 Harrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-46 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1739 E. Balto St

(c) Date signed by Registrar 3 1 1946 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30-46 19 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1946 to 3/28 1946.
and that I last saw h[illegible] alive on 3/28 1946.

Immediate cause of death	Duration
Acute Broncho Pneumonia	
Due to Chronic cardiitis	
Due to Cerebral Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Augusta St Date signed 3/31/46

G38867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38867

Registered No. 131a

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3128 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3128 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. New

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-6465

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Mary L. New

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 1864

8. AGE: Years 81 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name John New
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Uhrig
15. Birthplace Germany

16 (a) Informant Mrs Willard C. Dodge
(b) Address 3128 Harford Rd

17 (a) Hospital (Burial, cremation, or removal) BURIAL (b) Date thereof Apr 1 1946 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.
Location 5510 Harford Road

18 (a) Funeral director Mr. & Mrs. John W. Ingold, Son
(b) Address 501 W. Fayette St

19 (a) Filed Apr 1 1946 (b) Registered by registrar Harrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1946 at 2 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Mar 29 1946 and that I last saw h[illegible] alive on Mar 28 1946

Immediate cause of death: Uremia Lung — Duration: 48 hrs

Due to: Cardio Renal Disease — 4 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Thomas M. D.

Address 313 E Lanvale St Date signed Mar 29 1946

G38868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G38868 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S. Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 d
(e) Length of stay in Baltimore (yrs., mos., or days) 22 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 838 E. Ford Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gail Meyers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/46

8. AGE: Years / Months / Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name George Rob't Meyers
13. Birthplace Baltimore

MOTHER 14. Maiden Name Renee Y. Bonneville
15. Birthplace Florida

16 (a) Informant George Rob't. Meyers
(b) Address 838. E. Ford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1-46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A 6 Co

18 (a) Funeral director Bernard C. Harlan
(b) Address 121 E. West St

19 (a) ... (b) ...
(Date received by registrar) Registrar

MAR 31 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1946 to 3/30 1946. and that I last saw h[illegible] alive on 3/30 1946.

Immediate cause of death	Duration
Anoxia & Compression of medullary centers	
Due to Hydrocephalus & Meningocele	
Due to Arnold Chiari Syndrome	
Other Conditions Subdural fluid.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Mo[illegible] MD
Address 1213 S. Light Date signed 3/31/46

S. B. C. A. X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G38869 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Warrington Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Warrington Apts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Cobb McCormick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Willoughby W. McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1862

8. AGE: Years	Months	Days	If less than one day
84	2	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Cobb
13. Birthplace Mass.

MOTHER
14. Maiden Name Mary Poulson
15. Birthplace Mass.

16 (a) Informant Mrs. Jennie Comas Davis
(b) Address 305 Somerset Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1500 Eutaw Place.

19 (a) APR 1 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to March 1946, and that I last saw h[illegible] alive on March 29 1946

Immediate cause of death: Carcinoma of ovary

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence R Johnston M. D.
Address 4504 Roland Ave. Date signed 3/31/46

Dr. Winston X

VS 150

G38870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38870 Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 Chesterfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Wieland

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24 1873

8. AGE: Years	Months	Days	If less than one day
73	2	5	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Lambert
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Anna E. Rose
(b) Address 93 N Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Catonsville Md

18 (a) Funeral director Fullum Rose Inc
(b) Address 1219 E Fayette St

19 (a) MAR 31 1946 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1943 to March 29 1946, and that I last saw h alive on March 29 1946.

Immediate cause of death	Duration
Coronary Occlusion	20 min
Due to Chronic Hypertension	3 yrs
Due to Diabetes Mellitus	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Schneider M.D.
Address 1101 Mulberry Ave Date signed 3-30-46 M. D.

VS 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G38871 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Maybury Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All x

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Maybury Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Scholz

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1865

8. AGE: Years 77 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Chief Cutter

11. Industry or business Retired

FATHER 12. Name Valentine Scholz
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Ira C. Cathell, D. Bailey
(b) Address 3908 Maybury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director H. C. Cathell Inc.
(b) Address 1217 E. Fayette

19 (a) MAR 31 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V8412

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1946 to 3/28 1946 and that I last saw him alive on 3/27 1946.

	Duration
Immediate cause of death: Myocardial degeneration	5 yrs+
Due to: Arteriosclerosis	5 yrs+
Due to:	
Other Conditions: Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Machen M. D.
Address 6304 Belair Rd Date signed 3/28/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C38812 94a

Registered No. C38812

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 W. Hamburg alley (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME George Monroe Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs. G. Moore

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1899

8. AGE: Years 46 | Months 6 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Lumberton, N. C. (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name William Moore
13. Birthplace Lumberton, N. C.

MOTHER
14. Maiden Name Josephine Johnson
15. Birthplace Lumberton, N. C.

16 (a) Informant Mrs. G. Moore
(b) Address 1447 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-1946 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Wm. George H. Hall
(b) Address 1631 Druid Hill Ave.

19 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-1946, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

.....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 3-27-46

G38873 G38873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Low St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Low St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Venera Lamasa

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 219-16-8508

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12 1916

8. AGE: Years 30 | Months | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Matteo Lamasa
13. Birthplace Italy

MOTHER
14. Maiden Name Giuseppa Minafo
15. Birthplace Italy

16 (a) Informant Giuseppa Lamasa (Mather)
(b) Address 1015 Low St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1st (month) 1946 (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) 3-31-1946 (Date received by registrar) (b) Huntington Hillcrest, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1946 at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945 to 3/28 1946 and that I last saw h[illegible] alive on 3/28 1946

Immediate cause of death	Duration
(a) Pulmonary Th	
Due to (b)	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Homsteen M. D.
Address 733 Ampudia St Date signed 3/30/46

G38874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G38874

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Greenspring Ave

(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. Lavindale Home
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TILLIE SINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta
15. Birthplace Russia

16 (a) Informant Dan Singer

(b) Address 25 E Cross St

17 (a) Burial (b) Date thereof 3-31-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem

Location Washington Blvd

18 (a) Funeral director Jas. Lewis Inc

(b) Address 1439 E Balto St

19 (a) 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30-46 1946 at 7a M

21. I certify that death occurred on the date above stated: that I attended deceased from 7-6 1941 to 3-30 1946 and that I last saw h. alive on 3-30 1946.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Edmund Levin M.D.

Address Levindale Date signed 3-31-46

VS 150

G38875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38875 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 Layola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Layola Southway (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Ette Sadowsky

3 (b) If veteran, name war
3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Gershon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Aaron Sadowsky
(b) Address 2518 Layola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Hamilton Ave + Belair Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Baltimore St

19 (a) (b)
Date rec'd by registrar MAR 31 1946 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 1946
and that I last saw her alive on 30 Mar 1946.

Immediate cause of death: Coronary occlusion — Duration: 1 hr
Due to: arteriosclerosis — 40 yr
Due to: hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B Gross M.D.
Address 2404 Eutaw Place Date signed 4-1 1946

G38876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G38876 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1700 Warwick Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md County

(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1700 Warwick Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Simon Gurewitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rachael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Jack Gurewitz

(b) Address 1700 Warwick ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd or Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1946 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1945 to March 30 1946, and that I last saw him alive on March 30 1946.

Immediate cause of death Recurrent carcinoma of the stomach & metastases — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sidney R. Hellel Jr M. D.

Address 129 W. Lafayette St. Date signed March 31, 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 542

G38877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days),
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N Ethelbert Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pauline Hillier

3 (b) If veteran, name war —
3 (c) Social Security Acct. No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Fred Hillier
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 2 1899

8. AGE: Years	Months	Days	If less than one day
47	1	2	hr. min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

APR 1 – 1946 (b) Huntington Williams, Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 1946 at 5 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 30 19 46 to Mar 30 19 46 and that I last saw him alive on Mar. 29 19 46

Immediate cause of death Acute myeloid leukemia — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grant Wilmer M. D.
Address Johns Hopkins Hosp. Date signed 3/30/46

VS 150

Death is accident Room
was of our case
Special Necessary Dr Nelson

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38878 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 South Charles (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Eyerly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1895

8. AGE: Years	Months	Days	If less than one day
50 ?	9	26	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired Laborer
11. Industry or business National Enamel & Stamping Co

FATHER
12. Name Harry G. Eyerly
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Mattie Scully
15. Birthplace Balto. Md.

16 (a) Informant Harry T. Eyerly (Brother)
(b) Address 521 N. Bouldin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 Filed APR 1 1946 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 30 1946 at 2 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1946 to 3-30 1946 and that I last saw h-- alive on 3-30 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Heart failure	
Due to Arteriosclerotic heart disease	
Other Conditions Jaundice	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Gilford
Address J H H, Date signed 3 31 46 M D

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G38879 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Patrick F. DeeKwar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Violet E. DeeKwar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3rd 1875

8. AGE: Years	Months	Days	If less than one day
71	0	27	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Victoria Hotel

FATHER
12. Name Charles DeeKwar
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Dugan
15. Birthplace England

16 (a) Informant Violet E. DeeKwar
(b) Address 1028 Greenmount Ave

17 (a) Burial (b) Date thereof 4/2/46
(Burial, ~~cremation,~~ or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) APR 1 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944 to Mar 19 1946 and that I last saw him alive on 3/19 1946

Immediate cause of death: Acute Heart Failure — Duration

Due to: a Cardiac Infarction

Due to: Ch Myocarditis

Due to: Ch Rheumatic Heart

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Argyle St Date signed 3/31/46

VS 150

G38880

AB-100177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G38850

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs-36min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Ball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26-1946

8. AGE: Years | Months | Days | If less than one day: 4 hr. 36 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Ball
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Cox
15. Birthplace Va.

16 (a) Informant
(b) Address

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9am 3-28-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) Date received APR 1 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 5.55pM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1946, to 3-26 1946, and that I last saw him alive on 3-26- 1946

Immediate cause of death Atelectasis, fatal — Duration

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hedges & Palmer

Address Baltimore City Hosp. Date signed 3-29-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38881 HAUG

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G38881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County Anne Arundel
(c) City or town Brooklyn Hts. Baltimore 25 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Tungston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sabastian Haug

3 (b) If veteran, name war No.

3 (c) Social Security Account No. -

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Pauline Haug

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1864

8. AGE: Years 81 Months -8 Days -7 If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name Robert Haug
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Stutz
15. Birthplace Germany

16 (a) Informant Mrs Schorn
(b) Address 35 Admiral Road (Dundalk)

17 (a) Buried [redacted] (Burial, cremation, or removal) (b) Date there April 1-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Gor. Ritchie Highway

18 (a) Funeral director Milton Schellenberg
(b) Address 3914 S. Hanover St

19 (a) Filed APR 1 1946 (Date registrar) (b) Barrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946 at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1946 to March 29 1946, and that I last saw h[redacted] alive on March 29 1946.

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Arteriosclerotic Cardiovascular renal disease	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Shorofsky M. D. M. D.

Address 601 N. Monroe St Date signed 3/30/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38852 G38852

BALTIMORE CITY HEALTH DEPARTMENT

HB # 100265 CERTIFICATE OF DEATH 61 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 31 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5714 Condova Lane Holabird (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Margaret Ray Simmons

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Alfonzie Simmons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1914

8. AGE: Years	Months	Days	If less than one day
31	11	14	hr. min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clarence Johnson (d)
13. Birthplace Ga.

MOTHER
14. Maiden Name Margaret Farmer
15. Birthplace Ga.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-2-46 (month) (day) (year)
(c) Cemetery or crematory Rivera
Location Georgia
18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1058 W Montgomery
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS APR 1 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946 at 11:15 M
21. I certify that death occurred on the date above stated; that I attended deceased from March 30, 1946 to March 30, 1946 and that I last saw her alive on March 30, 1946
Immediate cause of death Respiratory Failure — Duration
Due to Acidosis & Coma
Due to Diabetes Mellitus
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert R. Fisher M.D.
M. D.
Address Balt. City Hospitals Date signed 3-30-46

X

G38883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G38883

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 S Eutaw
(c) Hospital or institution: N

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S Eutaw
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William E. Chase Jr

3 (b) If veteran, name war None

3 (c) Social Security Account No. 220-16-2597

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1908

8. AGE: Years	Months	Days	If less than one day
37 39	8	9	hr. min.

9. Birthplace a. a. Co, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm E Chase Sr
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Howard
15. Birthplace Md

16 (a) Informant Theodore Chase
(b) Address 602 S. Eutaw St

17 (a) Burial (b) Date thereof 4-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. Co Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

19 (a) (Date received by local registrar) APR 1 1946 (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/ 1946, at 2 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 1946, to Mar 29 1946 and that I last saw him alive on Mar 28 1946

Immediate cause of death Cardiac Decompensation
Pulmonary Edema — Duration about 10 days
Due to Cause undetermined
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Gaines M.D.
Address 504 W. Hamburg St 3/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

C38884 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1532 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgia Blakney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Chester

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-17-1916

8. AGE: Years 29 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Chester Blakney
(b) Address 1532 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) (Date rec'd by registrar) (b)

APR 1 - 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946, at 8 7/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to Mar 29 1946, and that I last saw her alive on Mar 29 1946.

Immediate cause of death: Acute Coronary Occlusion — Duration

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Franklin Culley M.D.

Address 1543 Penna Ave Date signed 3/30/46

X

Trans G38835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G38835

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 359 Marydale Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 359 Marydale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Elmer Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edna M Armstrong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1908

8. AGE: Years	Months	Days	If less than one day
37	10	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name William H Armstrong
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillie Braun
15. Birthplace Maryland

16 (a) Informant Mrs Edna M Armstrong
(b) Address 359 Marydale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3 1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3201 Frederick Ave

18 (a) Funeral director Harry A Wetzler Jr
(b) Address 4101 Edmondson Ave

19 (a) Date rec'd by registrar April 1946 (b) Huntingtor Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946 at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Hetrick M.D. Medical Examiner.
Date signed 31 March 46

G38836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

VS 9 G38836 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3430 6th Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Higgs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F		Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 30 46

8. AGE: Years	Months	Days	If less than one day
			6 hr. X min.

9. Birthplace Balt md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Newton Higgs
13. Birthplace Ga.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace

16 (a) Informant Newton Higgs
(b) Address 3430-6 St Brooklyn

17 (a) Burial (b) Date thereof April 1. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayr Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry H Wiltshire
(b) Address 4101 Edmondson Ave.

19 (a) (b) Registrar
(Date rec'd by registrar)

APR 2 1946 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Acute Cardio-respiratory failure.

Due to: Premature birth.

Due to: (wt 1 lbs.)

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur T. Hall Jr MD.
M. D.
Address St. Agnes Hosp. Date signed 3/30/46

2 Trans. G38887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38887 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cay ave & Dukeland
(c) Hospital or institution: West Balto. Gen. Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1249 N. Bentalow St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur E. Von Lossberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife Thelma Groves

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1875

8. AGE: Years	Months	Days	If less than one day
71	1	2	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Jeweler
11. Industry or business A. H. Fetting Co.

FATHER
12. Name Oscar von Lossberg
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Berg
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Thelma von Lossberg
(b) Address 1249 N. Bentalow St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 2 '46 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location North ave. & Gay St.

18 (a) Funeral director Harry H. Dithle
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 March 1946, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to 29 Mar 1946, and that I last saw him alive on 29 Mar 1946

Immediate cause of death	Duration
Resp. & Cardiac Failure	
Due to Cerebral Accident	
Due to Hypertension C.V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hector A. Bell, M.D.
Address West Balto. Gen. Hosp. Date signed 3/29/46

G38838 ✓ G38838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abram J Erdbrink

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5008

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carolyn

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Jul 13 1895

8. AGE: Years 50 51 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER 12. Name Walter Erdbrink

13. Birthplace Germany

MOTHER 14. Maiden Name Julia Smith

15. Birthplace Va.

16 (a) Informant Mrs Carolyn Erdbrink

(b) Address 126 S Ellwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3 1946 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location Baltimore Co Md

18 (a) Funeral director Wm H Lunch Home

(b) Address 2008 Orleans

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946 at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1946 to March 31 1946, and that I last saw h alive on 19

Immediate cause of death Subdural Hematoma — Duration

Due to Fractured Skull

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Fractured Skull, Subdural Hemat

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence March 31 at 7:30 A. M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down Flight of Stairs

23. Signature Julius Telhe, M. D.
Address Sinai Hospital Date signed 3/31/46

APR 5 1946

Howard J. Wilson, M. D. X

G38889 ✓ G38889

G38889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1469 Towson St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1469 Towson St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Doell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
White	Male	Married

6 (b) Name of husband or wife Anna Doell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1870

8. AGE: Years	Months	Days	If less than one day
76	1	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Wood turner
11. Industry or business

FATHER
12. Name William Doell
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Fisher
15. Birthplace Germany

16 (a) Informant Mrs. Marie Luber
(b) Address 407 N. Curley St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof April 2/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balty Co Md

18 (a) Funeral director Leland Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Filed Williams M.D. Registrar

APR 1 - 1946 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946 19 at 3A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 19 46 to 3/30 19 46.
and that I last saw h[illegible] alive on 3/30 19 46.

Immediate cause of death Cerebral apoplexy.

	Duration
Due to —	
Due to —	
Other conditions Arteriosclerosis Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Schmunk
Address 1337 S. Charles St Date signed 3/30/46. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G38830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4616 Rokeby Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4616 Rokeby Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Rokeby

3 (a) **FULL NAME** Aleta May Schwenk

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eugene M Schwenk

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Apr 21- 1904

8. AGE: Years 41 | Months 11 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Scranton Pa
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Joseph Paff
13. Birthplace Pa

MOTHER
14. Maiden Name Elizabeth Saynel
15. Birthplace Pa

16 (a) Informant Mrs. Henry P. Reist

(b) Address 4616 Rokeby Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 1- (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Rural

18 (a) Funeral director Uhler Funeral Home

(b) Address 2118 Orleans

19 (a) APR 1 - 1946 (Date rec'd by registrar) (b) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Mar 29 1946 and that I last saw him alive on Mar 28 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alta H Schwenk

Address 4709 Hurd Ave Date signed M. 3 D. 30 46

VS 150

X

C38891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C38891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 349 South Elkins (If rural give location)
(e) Citizen of foreign country? Eburnt (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD J. BERGER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Bernice
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan 20 1899

8. AGE: Years	Months	Days	If less than one day
47	2	11	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business

FATHER
12. Name Julius Berger
13. Birthplace Germany

MOTHER
14. Maiden Name Anna K Schoenels
15. Birthplace Ger

16 (a) Informant Mrs Bernice Berger
(b) Address 319 S Elkins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Wilmot Funeral Home
(b) Address 2008 Orleans

19 (a) APR 1 - 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/46 19 at 5:35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 3/31/46

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G38892 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Seville apts Lake Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Seville apts Lake Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Oliner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Harold Weiss

13. Birthplace Austria

MOTHER 14. Maiden Name Rebecca

15. Birthplace Austria

16 (a) Informant Abraham Oliner

(b) Address Sheffield Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location East Balto St

18 (a) Funeral director Jack Lewis Inc

(b) Address 1459 E. Balto St

19 (a) (Date rec'd by Registrar) (b) Signature for Williams, M.D. Registrar

APR 1 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31- 1946 at 1155 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to 3-31 1946, and that I last saw her alive on 3-30 1946.

Immediate cause of death	Duration
Coma	
Due to Hemorrhagic arteriosclerosis	
Due to Chronic nephritis	
Due to Myocarditis	
Other Conditions Hypostasis -	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N B Reedle

Address 3314 - W. North Ave Date signed 3/31/46 D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 638893 (ora)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 652 S- North Point Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lottie Fredkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1938

8. AGE: Years	Months	Days	If less than one day
8			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sidney Fredkin
13. Birthplace Md.

MOTHER 14. Maiden Name Saray Berman
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Jack Levins Inc
(b) Address 1739 E. Baltimore St

19 (a) (Date rec'd by Local Reg.) APR 1 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30- 1946 to 3-31- 1946 and that I last saw her alive on 3-31- 1946

Immediate cause of death: Peripheral vascular collapse — Duration 4 hrs

Due to Septicemia with pneumonia — 2 days

Due to Unknown organism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Pendleton
Address Johns Hopkins Hosp Date signed 3 1 46

G38894 ✓ G38894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 N. Caroline St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E. Russell

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-01-9386

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank Russell
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) January 1891

8. AGE: Years 55 | Months 2 | Days ? | If less than one day ###### hr. ###### min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER — 12. Name Tylow
13. Birthplace Virginia

MOTHER — 14. Maiden Name ? ?
15. Birthplace England

16 (a) Informant Edward T. Russell
(b) Address 1814 N. Caroline Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Morelands Park
Location Taylor Avenue Balto: Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) APR 1 - 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1945 to March 19 and that I last saw h~~e~~r alive on Mar 30 1946

	Duration
Immediate cause of death: Coronary thrombosis	1 hour
Due to: Arteriosclerosis	over 1 year
Due to: Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.

Address 1039 N Calvert St Date signed 3/30/46

Balt ~ X

G38895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 6 ✓

Registered No. G38895

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Rock Hall (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Croxford ✓

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George Henry Croxford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1893

8. AGE: Years 52 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Philadelphia Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Walter Stanton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Burns
15. Birthplace Ohio

16 (a) Informant Ernest B. Croxford
(b) Address 1111 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Maryland

18 (a) Funeral director George L. Schwartz
(b) Address 2101 Frederick Avenue

19 Date received by local registrar APR 1 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1946 to 3-30-1946, and that I last saw h alive on 3-30 1946

Immediate cause of death: Pneumonia — Duration:
Due to: Meningitis
Chronic Diabetes Mellitus
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Henry Wirt Hodges M. D.
Address St Agnes Hospital Date signed 3-31-46

X

VS 150

G38896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. G38896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland General Hospital
(c) Hospital or institution: Madison & Howard Streets 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs. 4 Mos. 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Nonc
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES F. PETERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 26/1942

8. AGE: Years 3 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None - Baby.

11. Industry or business —

FATHER
12. Name Alvah K. Peters.
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Josephine E. Bradshaw.
15. Birthplace Bells Island Md.

16 (a) Informant Mrs. Alvah
(b) Address 702 Newington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April-1-46 (month) (day) (year)

(c) Cemetery or crematory Western Cemetery.
Location Baltimore - Md.

18 (a) Funeral director Charles H. Schwab.
(b) Address 505 N. Monroe St.

19 (Date rec'd by registrar) APR 1 - 1946 Huntingtor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1946 at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1946 to 3/29 1946 and that I last saw him alive on 3/29 1946.

Immediate cause of death Intracranial hemorrhage due to depressed & fissured fracture of Comminuted Occipital bone contusion & laceration of brain

Due to Fall (accidental)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3/29/46
Major findings of operation: Fracture as above.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3/29 at 6:50 P.M.
(c) Where did injury occur? Baltimore (City or town) — (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell from Porch at Home

23. Signature Carlton Brinsfield M.D.
Address Md. Gen. Hosp. Date signed 3/29/46 M.D.

VS 150

For Dr. J. R. Davis, by Howard D. Lawrence, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G38897 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East Pr.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 194 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Married

6 (b) Name of husband or wife Wm. E. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-1891

8. AGE: Years	Months	Days	If less than one day
54	9	29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. Holland

13. Birthplace Md.

MOTHER 14. Maiden Name Josephine Hallein

15. Birthplace Md.

16 (a) Informant Thomas Hammond

(b) Address 704 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

19 (a) APR 1 - 1946 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30- 1946 at 5 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Carcinoma of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 3-30-46

G38898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1172

Registered No. G38898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 South Decker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 South Decker (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John P. Heerlein Herrlein

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Delia

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.): May 14 1877

8. AGE: Years 68 | Months 10 | Days 16 | If less than one day ____hr. ____min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business: Retired

FATHER
12. Name: John Herrlein
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Lang
15. Birthplace: Germany

16 (a) Informant: George Herrlein
(b) Address: 611 W. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 2 46 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Rd

18 (a) Funeral Director: Martin H. & Dupuis Sons
(b) Address: 1910 Bolton St.

19 APR 1 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/46 19____, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions: Peptic Ulcer

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: John R. Davis M.D. Medical Examiner.
Date signed 3/31/46

93D

VS 151

G38899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

G38899 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Presbury St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Crook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Contractor

FATHER
12. Name Louis Brook
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta Grossman
15. Birthplace Russia

16 (a) Informant Mrs. Eva Cohen
(b) Address 2102 Presbury St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 46 (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1126 W. North Ave Hunting for Williams, Md

19 (a) APR 1 - 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946 at 10:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Mar 1946 and that I last saw him alive on 3/31 1946

Immediate cause of death — Duration

Acute Coronary Thrombosis

Due to Hypertensive CVD

Due to Rheumatic CVD

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harland Applefeld M.D.
Address 2511 Reisterstown Rd Date signed 3/31/46

VS 150

G38900 GINZLER G38900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161 (Registered No.)

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Wapole Drive Oak Grove (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ginzler Michael Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-46

8. AGE: Years | Months | Days: 4 hr. min. If less than one day

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name arthur ginzler
13. Birthplace Butler Pa

MOTHER
14. Maiden Name Rose Kleinick
15. Birthplace U.S.

16 (a) Informant Major ArthurM Ginzler
(b) Address 2 Maple Drive Balto 2

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof April 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W. North Ave.

19 (a) APR 1 1946 (Date received by registrar) (b) Thurlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 31 1946 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1946 to 3-31 1946 and that I last saw h.e alive on 3-31 1946

Immediate cause of death: Respiratory failure

Due to: Erythroblastosis Fetalis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E Dorman M.D. M. D.
Address Johns Hopkins Hosp Date signed 3/31/46

VS 150

G38901 BALTIMORE CITY HEALTH DEPARTMENT G38901

CERTIFICATE OF DEATH 33a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2818 W. Mosher St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 W Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Albert Hoover

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1- 1884

8. AGE: Years 61 | Months 7 4 | Days 1 29 | If less than one day hr. min.

9. Birthplace Butler - Maryland
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Railroad

FATHER 12. Name Thomas Hoover

13. Birthplace Pa

MOTHER 14. Maiden Name Ann Raysdale

15. Birthplace Ind.

16 (a) Informant Mrs. Julia S. Hoover

(b) Address 2818 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/46 (month) (day) (year)

(c) Cemetery or crematory Western

Location Balto Md

18 (a) Funeral director Geo. L. Boyer Jr

(b) Address 1512 Hollins St

19 (a) APR 1 - 1946 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1946, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1946, to March 30 1946, and that I last saw h[illegible] alive on March 29 1946

Immediate cause of death	Duration
Broncho pneumonia	4 days
Due to Acute Bronchitis	2 days
Due to Grippe	1 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Jas McDermott

Address 1136 Poplar Grove St Date signed 3/31/46 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G38902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days 15
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Married

6 (b) Name of husband or wife Eleanor Briscoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/19/1899

8. AGE: Years	Months	Days	If less than one day
46	7	11	hr. min.

9. Birthplace St Mary's County (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Robert Briscoe
13. Birthplace St Mary's Co. Md.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace St Mary's Co. Md

16 (a) Informant Wife
(b) Address 1113 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Leo D. Kelly
(b) Address 4308 Pinkney Road

APR 1 - 1946 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1946, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11:45 A.M. 3/30 1946, to 8:45 P.M. 3/30 1946, and that I last saw him alive on 3/30 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. McDonald, M.D.
Address 1446 Cary Date signed 3/31/46

VS 150

G38903 Dr. Harding
4810 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52a

G38903 Registered No.

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5002 Gunther Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 Gunther Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew B. Gagliardi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1901

8. AGE: Years	Months	Days	If less than one day
44	3	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation cement finisher
11. Industry or business

FATHER
12. Name John L. Gagliardi
13. Birthplace Italy

MOTHER
14. Maiden Name Adalaide ?
15. Birthplace Italy

16 (a) Informant Mrs. Adalaide Gagliardi
(b) Address 5002 Gunther Avenue

17 (a) Burial (b) Date thereof 4/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Date received APR 1 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29th, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to 3-29 1946.
and that I last saw h[illegible] alive on 3-1-46 19

Immediate cause of death: Hypernephroma, left kidney — Duration 1 yr.
Due to: Pulmonary Tuberculosis — Duration 1 yr.
Due to:
Other Conditions: Metastases

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence D. Serra
Address 11 E. Chase St Date signed 4/1/46

X Serra

G38904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38904 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 Kennedy Ave.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 74 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Kennedy Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Josephine Sperzel

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 19, 1871

8. AGE: Years	Months	Days	If less than one day
74	4	11	-- hr. -- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Alousius Sperzel
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Floren
15. Birthplace Germany

16 (a) Informant Mr. Joseph A. Sperzel
(b) Address 3728 Edmondson Ave.

17 (a) Burial (b) Date thereof 4/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Henry W. Means Esq. Inc.
(b) Address 805 N. Calvert St.

19 (a) Filed APR 1 1946 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 March 1946, at 7.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 March 1946, to 30 March 1946, and that I last saw h[illegible] alive on 30 March 1946

Immediate cause of death Cerebral Hemorrhage — Duration 12 hrs.

Due to Hypertension H.D. —

Due to ----

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation ----

Major findings of operation: ----

of autopsy: ----

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ----
(b) Date of occurrence ---- at ---- M
(c) Where did injury occur? ----
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---- While at work? ----
(Specify type of place)
(e) Means of injury ----

23. Signature Henry J. Conley M.D.
Address 115 E. Eager St. Date signed 4/1/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

P3D

Registered No. G38905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 N. Carrollton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE PLONK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Plomk
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Marje ?
15. Birthplace Czechoslovakia

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 4-
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a)
(Date rec'd by registrar) Registrar

APR 1 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1944, to March 30 1946, and that I last saw h er alive on March 25th 1946.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 hrs.
Due to Chronic Cardio-Vascular Disease	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael A. Abrams M.D.
M. D.
Address 1520 Eutaw Place Date signed 3/30/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38:825 — BALTIMORE CITY HEALTH DEPARTMENT — G38:906 Registered No.

CERTIFICATE OF DEATH 97

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 S. Mount Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 337 S. Mount Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Minnie Mueller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Paul
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1869

8. AGE: Years 77 | Months 1 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Not known
13. Birthplace: Germany

MOTHER
14. Maiden Name: Not known
15. Birthplace: Germany

16 (a) Informant: Mr. Paul Mueller
(b) Address: 337 S. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: George Leimbach
(b) Address: 525 Lyndhurst Street

19 (Registered by registrar) APR 1 - 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1945, to Mar. 31, 1946 and that I last saw her alive on Mar. 31, 1946

Immediate cause of death	Duration
Congestive heart failure	16 days
Due to Arteriosclerosis	
Due to Arterial hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A Kupp
Address 3030 Edmondson Ave. Date signed 4/1/46

VS 150

Huntington for Williams, MD

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38907

LORINE AMALIE SACHSE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. G38907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Valleythorpe
(If outside city or town limits, write RURAL and give name of county)
(d) Street No. 1307 Elm Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Lorine ~~Beatrice~~ Amalie Sachse

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1930

8. AGE: Years 15 | Months 5 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation At School

11. Industry or business .....

FATHER
12. Name Henry G. Sachse
13. Birthplace Maryland

MOTHER
14. Maiden Name Lorine Lovell
15. Birthplace Maryland

16 (a) Informant Henry G. Sachse
(b) Address 1307 Elm Road, Valleythorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2-1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director Burge Funeral Home
(b) Address 3631 Falls Road

19 (a) ..... (b) Huntington Williams M.D.
(Signature of registrar)

APR 1 - 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946 at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture Intrakranial hemorrhage.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-29-46 at 11:50 P.M. 1944
(b) Where did injury occur? Monroe & Wilkens Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by auto.

23. Signature Benedict Mastaroli M.D.
Medical Examiner.
Date signed 3-30-46

G38903 G38903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS MOYLAN

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 213-07-0031

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married .

6 (b) Name of husband or wife: Rose R. Moylan
6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1887

8. AGE: Years	Months	Days	If less than one day
58	7	9	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Chief Clerk
11. Industry or business: Beth. Steel. SP. PT.

FATHER
12. Name: Thomas Moylan
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Annie Hyland
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Rose Moylan - widow
(b) Address: 2900 N. Calvert street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-46 (month) (day) (year)
(c) Cemetery or crematory: Most Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE . & BROADWAY

19 (a) Date received by registrar APR 1 - 1946 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946 at 8.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1943 to March 29 1946 and that I last saw h[illegible] alive on Mar 27 1946

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerotic Cardiac vascular Renal Disease.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [signature]
Address: 1331 North Ave Date signed 3-30-46 M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38909

CMK-100086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G38909 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 2914 Hanover Street (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Brickhouse

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clinton E. Brickhouse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7-1879

8. AGE: Years	Months	Days	If less than one day
66	11	29	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Coffey (D)
13. Birthplace Pa.

MOTHER
14. Maiden Name Alice Clark (D)
15. Birthplace Pa.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md.

18 (a) Funeral director A. Robert Ellis
(b) Address 140 St. Paul St.

19 (a) (b)
Registrar

APR 1 1946

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 46, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 19 46, to March 30 19 46, and that I last saw h er alive on March 30 19 46

Immediate cause of death	Duration
Carcinoma of the Cervix Uteri with multiple Metastasis	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank E. Nitterville M. D.
Address Balt. City Hosp. Date signed 3-30-46

X

Taken to Morgue for approval [redacted] Morgan

638910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) May 20 years
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 E Lorraine Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev Joseph Graham Morgan

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Bernice H. Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1881

8. AGE: Years 64 | Months 7 | Days 17 | If less than one day: hr. min.

9. Birthplace Salisbury, Md. (Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business

FATHER 12. Name Richard Morgan
13. Birthplace

MOTHER 14. Maiden Name Laura Calloway
15. Birthplace Md.

16 (a) Informant Mrs. Bernice H. Morgan
(b) Address 407 E. Lorraine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 2 1946 (Date received by registrar) (b) Substitute for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1946, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1946 to March 29 1946; that I last saw him alive on March 27 1946

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension and Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George T. Stevenson M.D.
Address Union Memorial Hospital Date signed 3/29/46

VS 150

For Dr. R. Davis by Howard S. Mitchell, M.D.

C38911 BALTIMORE CITY HEALTH DEPARTMENT C38911
CERTIFICATE OF DEATH 484 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5115 Gwynn Oak Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MARIE C. DIETRICH
3 (b) If veteran, name war no
3 (c) Social Security Account No. none
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Andrew J. Dietrich, Jr.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 21, 1902
8. AGE: Years 43 | Months 7 | Days 9 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Internal Revenue Dept.
11. Industry or business U. S. Gov't.

FATHER
12. Name Henry C. Pfaff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katherine Heimiller
15. Birthplace Balto.

16 (a) Informant Mr. William H. Pfaff
(b) Address 5113 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 1 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1946, at 935 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1946 to 3-30 1946. and that I last saw her alive on 3-30 1946.

Immediate cause of death: Carcinoma of cervix c metastasis — Duration
Due to
Due to
Other Conditions: Secondary external & internal bleeding
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hayle Brunell M.D.
Address Y.M.H. Date signed 3-30

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 88850 C38912 BALTIMORE CITY HEALTH DEPARTMENT C38912

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-8-25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimor e
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Herbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE VIRGINIA PARRISH

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry Parrish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1895

8. AGE: Years 50 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jesse Beall
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Robinson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 1 - 1946 (Date rec'd by registrar) (b) Filing for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946, at 9:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944, to Mar. 30 1946, and that I last saw h. alive on March 30 1946

Immediate cause of death: Pulmonary Tuberculosis Duration ?
Tuberculous Enteritis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 3/31/46

VS 150

G38913 BALTIMORE CITY HEALTH DEPARTMENT G38913

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Broadway
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL M. GIPE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1892

8. AGE: Years	Months	Days	If less than one day
53	6	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Albert B. Gipe
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Wales
15. Birthplace A. A. Co., Md.

16 (a) Informant Miss E. Virginia Gipe
(b) Address 417 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1946 Wellington Williams, M.D. Registrar
(Signature of registrar)

WS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 March 1946 to 30 March 1946, and that I last saw her alive on 30 March 1946

Immediate cause of death	Duration
Cerebro-vascular accident	1 day
Due to hypertensive arteriosclerotic cardiovascular disease	6 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jay M. Zamoiski M.D.
Address 2854 Hanford Rd Date signed 1 Apr 1946

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38914 G38914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3021 Cresmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3021 Cresmont Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN H. TWELBECK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Louise R. Twelbeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1904

8. AGE: Years	Months	Days	If less than one day
42	0	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Mortgage Loan Co.
11. Industry or business Union Trust Co.

FATHER
12. Name Henry H. Twelbeck
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name -- Zuhone
15. Birthplace Germany

16 (a) Informant Mrs. Louise R. Twelbeck
(b) Address 3021 Cresmont Ave.

17 (a) Burial (b) Date thereof 4/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] 1946 [illegible] Williams, M.D.
(Permit issued by registrar)

VS-130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to March 30 1946 and that I last saw him alive on May 29 1946

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to	
Due to	
Other Conditions Hypertension	Indef
Major findings of operation:	
Date of operation	
of autopsy	

(Include pregnancy within 3 months of death)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Bark M.D.
Address 2727 N. Charles St. Date signed Apr 1-46

X

[redacted] G38915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G38915

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 849 Lemon St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A. Curry

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race C | 6 (a) ~~Single, married~~, widowed, ~~or divorced~~.

6 (b) Name of husband or wife Alice Curry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and State)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Florence Rogers
(b) Address 849 Lemon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 1 1946 [illegible] Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 March 1946, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kefauver M.D. Medical Examiner.
Date signed 28 March 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G38916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2555 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 39

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2555 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina Majeszky

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Henry A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 1879

8. AGE: Years	Months	Days	If less than one day
67	1	7	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilhelm Braun
13. Birthplace Austria

MOTHER
14. Maiden Name Marie (?)
15. Birthplace Austria

16 (a) Informant Henry A Majeszky
(b) Address 2555 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson ave + Longwood St.

18 (a) Funeral director Harry W Kitzell
(b) Address 4101 Edmondson ave

19 (a) Received by Registrar APR 1 1946

Hunting for Witness, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/15 1946 to 3/30 1946 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	10 day
Due to Hypertension	
Due to Arterial Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ethel Carlson M. D.
Address 2145 W Balt St Date signed 4/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

638917 183 638917 Registered No.

638917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-
(c) Hospital or institution: South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Seagull Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - - 1933

8. AGE: Years 13 | Months 12 | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county and state)

10. Usual Occupation attends School

11. Industry or business

FATHER
12. Name Charles Jones,
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Charles Jones
(b) Address 210 - Sea Gull Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-1-46 (month) (day) (year)

(c) Cemetery or crematory
Location Emposia Va.

18 (a) Funeral director A. Halstead
(b) Address 96 Enid Hill Ave.

19 (a) APR 1 1946 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1946, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/2

(a) Date of injury 3-31-46 at P. M.
(b) Where did injury occur? Quarry near Edmond
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no.
(d) Means of injury Dropped

23. Signature Howard J. Charles M.D.
Medical Examiner.

Date signed 4-1-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G38918 CERTIFICATE OF DEATH 459 G38918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 185 days
(e) Length of stay in Baltimore (yrs., mos., or days) 185 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Eastern Pkwy. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Begley, Daniel Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frances Braudigan
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1899

8. AGE: Years	Months	Days	If less than one day
47	1	30	hr. min.

9. Birthplace Newark, N.J. (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Edward Begley
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Dolan
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof APR. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory HOLY SEPULCHER
Location EAST ORANGE, N. J.

18 (a) Funeral director Wilkins Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1946 (b) Registrar
(by registrar)

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 31 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1945, to Mar. 31 1946, and that I last saw him alive on Mar. 31 1946

Immediate cause of death Squamous cell carcinoma, primary right lower alveolar ridge with regional extension. — Duration: more than 18 mos

Due to Other Condition: Pneumonia, bronchial, terminal, — Duration: Few days

Due to — Duration: Unknown

Other Conditions Cardiac failure

(Include pregnancy within 3 months of death)
Date of operation 10/16/45
Major findings of operation: Carcinoma side of face, mandible & neck
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 4/1/46
US Marine Hospital, Balto, Md.

G38919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G38919

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3554 Buena Vista Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3554 Buena Vista (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie M. Grove
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harry W. Grove
6 (c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) Sept 6 1874
8. AGE: Years 71 Months 6 Days 25 If less than one day hr. min.
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Robert McClelland
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Meyers
15. Birthplace Balto. Md

16 (a) Informant Harry W. Grove
(b) Address 3554 Buena Vista Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - 3 - 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Taylor Ave
18 (a) Funeral director John C. Mally Sons
(b) Address 243 E. Oliver St
19 APR 2 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 31 - 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1946, to March 31 1946 and that I last saw h[illegible] alive on March 31, 19 46

	Duration
Immediate cause of death: Cardiac Decomp.	1 wk
Due to: Hypertensive CVD	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Shumaker M. D.
Address 371 Tally Rd Date signed 4 1 46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G38920 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Joppa (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country –

3 (a) FULL NAME Nellie Archer Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lacy H Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May - 30 - 1900

8. AGE: Years 45 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Franklin Archer
13. Birthplace: Iowa

MOTHER
14. Maiden Name: Susie Wright
15. Birthplace: Virginia

16 (a) Informant: Lacy H. Jones
(b) Address: Joppa - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2 - 46 (month) (day) (year)
(c) Cemetery or crematory: Mountain Christian Cem
Location: Harford Co. Md.

18 (a) Funeral director: Clarence E. Arthur
(b) Address: Joppa Md.

19 (a) APR 2 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar - 31 - 1946, at 4 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 27 1946, to Mar 31 1946, and that I last saw her alive on Mar 31 1946.

Immediate cause of death: Pulmonary Embolism — Duration

Due to

Due to

Other Conditions: Pneumonia, A.b.d.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: George H. Schlesinger M.D.
Address: 111 Alex. St. Date signed 3/31/46

VS 150

111 Alex. St. Schlesinger

G38921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √93D

G38921

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1170 W. Hamburg st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town V
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1170 W. Hamburg st
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary, Annie, Metzger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/22/56

8. AGE: Years 89 | Months 10 | Days 9 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant [redacted] W. Metzger
(b) Address 2913 Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director Ambrose Doe
(b) Address 414 N. Franklintown rd

19 (d) APR 2 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946, at 1 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to March 31 1946, and that I last saw h[illegible] alive on March 29 1946

Immediate cause of death	Duration
arteriosclerotic Heart disease	4 years
Due to cardiac decompensation	1 yr.
Due to	
Other Conditions generalized arteriolosclerosis	4 years

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Glass M. D.
Address 876 Wash Blvd Date signed 1 Apr. 1946

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied: The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT BAKER

CERTIFICATE OF DEATH 46E

Registration No. 6G3892 6G3892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden Ave
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband Alexander Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1865

8. AGE:	Years	Months	Days	If less than one day
	79	5	19	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business At Home

FATHER
12. Name Archer Atkinson
13. Birthplace Va.

MOTHER
14. Maiden Name Mollie Dews
15. Birthplace Va.

16 (a) Informant Donald Baker
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/46 (month) (day) (year)
(c) Cemetery Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 2 1946 (Date received by Registrar) (b) Huntington for Williams, Mgr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1946 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1946 to 3/31 1946 and that I last saw h[illegible] alive on 3/31 1946

Immediate cause of death	Duration
Cardio Vascular Collapse	5 days
Due to Chronic Cholecystitis	
Due to Cholelithiasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/27/46

Major findings of operation: Ca. of Bowel - Sigmoid Ca

Date of autopsy — Findings

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Phillips
Address Md. Gen. Hosp. Date signed 3/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38923

CMK-90378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G38923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 5- 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Horton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30-1874

8. AGE: Years	Months	Days	If less than one day
71	6	0	hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name John Pennington
13. Birthplace Delaware

MOTHER
14. Maiden Name Lydia Cutley
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

APR 2 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946, at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1944, to March 30 1946, and that I last saw h er alive on March 30 1946

Immediate cause of death Bronchopneumonia

Duration

Due to Bronchiectasis chronic

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Moderate bronchopneumonia with pulmonary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Dorsey Walton M. D.

Address Balto City Hosp. Date signed Apr. 1, 1946

C38924 **HEALTH DEPARTMENT—CITY OF BALTIMORE** C38924

CERTIFICATE OF DEATH 1310

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 2108 Lake Ave. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME William Howard Cobb Jr. — If U. S. Veteran specify WAR

(a) Residence: No. 2108 Lake Ave St., Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced - (write the word)
M.	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Martha Cobb

6. DATE OF BIRTH (month, day, year) 11/9/75

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	4	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Printer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. John Cox Sons

10. Date deceased last worked at this occupation (month and year) 1937

11. Total time (years) spent in this occupation 30 yrs

12. BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

FATHER

13. NAME George Cobb

14. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

MOTHER

15. MAIDEN NAME Virginia Reynolds

16. BIRTHPLACE (city or town) (State or country) Virginia

17. INFORMANT Mrs. Ellen Cobb (Address) 2108 Lake Ave

18. BURIAL, Place Green Mount Balto. Date 4/3 1946

19. UNDERTAKER William Cook Inc. (Address) 217 St. Paul St.

APR 2 - 1946 19 Huntington Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 1, 1946

22. I HEREBY CERTIFY, That I attended deceased from May, 1942 to April 1, 1946.

I last saw him alive on March 24, 1946. Death is said to have occurred on the date stated above, at 7 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertensive Cardio-Renal	
Valvular Disease	1942

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) W. Grafton Hershfurger M. D.

(Address) 214 Medical Sci. Bldg.

Information should be carefully supplied. Exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. OCCUPATION is very important.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

638923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Northwood
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Northwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lantenschlager

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr 1, 1862

8. AGE: Years: 83 | Months: 11 | Days: 30. | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER
12. Name: Adam Lantenschlager
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna M. Hares
15. Birthplace: Germany

16 (a) Informant: J. H. Corthelle
(b) Address: 400 Northwood

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore Md

18 (a) Funeral director: Wilhom Bros Inc
(b) Address: 1217 N Paul St

19 (a) Date rec'd by Local Reg. APR 2 - 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31/1946 to 3/31/1946 and that I last saw h.e.r alive on 3/31/1946

Immediate cause of death: Myocardial insufficiency — Duration: 1 day

Due to: Chronic myocarditis.

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Geo. A. Sanders
Address 1207 E North Ave Date signed 4/1/46

VS 150

X

Dr. Worsley
7900 Alameda

FOREMAN

C38926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4516 Falls Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4516 Falls Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida B. Foreman.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Leonard C. Foreman

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) April 27, 1898.

8. AGE: Years	Months	Days	If less than one day
47	11	3	hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Randolph Mallonee
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Lurall
15. Birthplace Va.

16 (a) Informant Leonard C. Foreman
(b) Address 4516 Falls Road.

17 (a) Burial (b) Date thereof Apr 2, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lurall Ridge
Location Catonsville, Md

18 (a) Funeral director Janet Wink's Sons
(b) Address Manchester Md

19 (a) Registered APR 2 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946 at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1946 to Mar 30 1946 and that I last saw her alive on Mar 30 1946.

Immediate cause of death	Duration
Abdominal Carcinamatosis	2 yrs
Due to Carcinoma of Cervix with metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Kenneth L. Worsley Jr. M. D.
Address 7900 Alameda Date signed April 1, 1946

X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

For Registrar
2306 St. Paul St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G38927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 Powers St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Powers St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie L. Mason.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Wm. A. Mason
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1877

8. AGE: Years 68 | Months 5 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Wm. A. Mason
(b) Address 800 Powers St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Thomas F. Bowen
(b) Address 3615-17 Eastern Ave.

19 (a) Apr 2 1946 registered by (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1946; at 6 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940, to March 29 1946, and that I last saw her alive on March 29 1946

Immediate cause of death	Duration
Coronary thrombosis	10 min
Due to Arteriosclerosis	1 year
Due to	
Other Conditions Chronic Hypertension	3 Months

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elbert H. Hartman M.D.
Address 2306 St Paul Date signed 4/11/46

G38928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G38928 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: Sinai Hospital - 13

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County.....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3016 Keswick Road.
(If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) FULL NAME James L. JUSTICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife Nellie Justice

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 21 1889

8. AGE: Years 56 | Months 9 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Labour

11. Industry or business Balto Water Dept.

FATHER
12. Name James L. Justice
13. Birthplace Maryland.

MOTHER
14. Maiden Name Alice Free.
15. Birthplace Maryland.

16 (a) Informant Nellie Justice

(b) Address 3016 Keswick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2/46 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Hampden

18 (a) Funeral director Thomas F. Donovan

(b) Address 36 (5-17 Edmondson Ave.

19 (a) APR 2 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 30 1946 at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1946 to 3/30 1946, and that I last saw him alive on 3/30 1946

	Duration
Immediate cause of death Carcinoma of lung	
Due to	
Due to	
Other Conditions Marked coronary arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation.....

Major findings of operation:.....

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature Daniel Hemberger M. D.

Address Sinai Hospital Date signed 3-31-46

VS 150

Dr. Bacon

G38929 Corrected

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115C

Registered No. G38929

MARGIN RESERVED FOR BINDING

The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 Dillchester Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Dillchester Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Lynn Shock.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1943

8. AGE: Years	Months	Days	If less than one day
2	3	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name J. Donald Shock. Sr.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Laura B. Hall.
15. Birthplace Maryland.

16 (a) Informant J. Donald Shock.
(b) Address 425 Dillchester Ave

17 (a) Burial (b) Date thereof April 3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Sisters
Location Balto Co. Md

18 (a) Funeral director Thomas P. Donovan
(b) Address 3615-17 Chestnut Ave

19 APR 2 - 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1946 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to March 31 1946, and that I last saw her alive on March 30 1946.

Immediate cause of death	Duration
Acute Nephritis	15 days
Due to Infected throat	15 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature Walter C. Bacon M. D.
Address 100 E. 20th St. Date signed 4/1/46

VS 150

X

G38930 G38930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 N Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1711 No Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Seidel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Morris
13. Birthplace Russia

MOTHER 14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Sarah Seidel
(b) Address 1711 N Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-46 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Blvd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1698 Pitts St

1946 APR 2 (b) (Date of Registration) 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1- 1946, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to April 1, 1946, and that I last saw h[illegible] alive on 4/1 1946.

Immediate cause of death	Duration
Cardiac Decompensation	3 mos.
Due to Cardiac Hypertrophy + Dilatation	10 years
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gustave Cooper
Address 2201 Eutaw Place Date signed 4/5/46

X

0389.31

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

0389.31 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 Hollins St.
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR I. JOYCE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kathern M. Joyce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1905

8. AGE: Years	Months	Days	If less than one day
40	6	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business Joseph Cafe

FATHER
12. Name Franklin P. Joyce
13. Birthplace Baltp., Md.

MOTHER
14. Maiden Name Elva Denhauldt
15. Birthplace France

16 (a) Informant Mrs. Kathern M. Joyce
(b) Address 829 Hollins St.

17 (a) Burial (b) Date thereof 4/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 2 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH March 31, 1946, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1946 to 3-31 1946 and that I last saw h alive on 3/31 1946.

Immediate cause of death	Duration
(a) Acute Cardiac Failure	1 da
Due to Coronary Disease	2 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph H. Lancaster
Address 629 Washington Blvd signed 4/2/46

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G38932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 N. Eutaw St.
(c) Hospital or institution: Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1648 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sheffield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/28/46

8. AGE: Years | Months | Days | If less than one day 8 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Sheffield
13. Birthplace Balto.

MOTHER
14. Maiden Name Marie Schultz
15. Birthplace Balto.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 30 1946 Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 2 1946 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28- 1946 at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1946 to 1946, and that I last saw h[illegible] alive on 3-28 1946.

Immediate cause of death	Duration
Atelectasis Premature	
Due to Prematurity	
Due to	
Other Conditions Congenital abnormality of R. foot & hand	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold M. Maudsley M.D.

Address 1.6.64 Date signed 3/29

VS 150

F 3389 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

145a

G38933 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL, and give town)
(d) Street No. Alden Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Mae Cunspia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas Jordan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Boston Mass. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Thomas Jordan Mac Cunspia
(b) Address 7-6 Alden Drive

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 4 2 46 (month) (day) (year)
(c) Cemetery or crematory
Location Boston Mass.

18 (a) Funeral director James J. Bruce & Inskeep
(b) Address 1407 Eastern Ave Rd

19 (a) APR 2 1946 (b) [illegible] Hunting for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946 at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary embolism

Due to Thrombosis of inferior vena cava

Other Conditions Pregnancy, 5½ mos.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Frederick J. Wallace M.D.

Date signed April 1, 1946

Howard J. Sinclair, Chief Medical Examiner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G38934 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2551 McCulloh St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alice L. Stanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife William A. Stanley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th 1866

8. AGE: Years 79 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Dennis N. Keeley
13. Birthplace Va.

MOTHER
14. Maiden Name Amelia Ann Russell
15. Birthplace Va

16 (a) Informant Alvin Stanley
(b) Address 2525 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto, Md.

18 (a) Funeral director Boyer & Wagner H. Wright
(b) Address 721 Eutaw St

19 (a) (b) (Date rec'd by Registrar) Registrar

APR 2 - 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945, to March 28 1946 and that I last saw h e alive on March 27 1946

Immediate cause of death Diabetes Mellitus — Duration since Nov '45

Due to

Due to

Other Conditions Emphysematous chest Bronchitis Alphabetic Mitral Insuff (Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

Complete PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph L. Young

Address 624 E Monument St Date signed 4/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

C38935 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 S. Bylias Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren H. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/7/1922

8. AGE: Years 24 | Months - | Days 23 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Mitchell
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Virginia

16 (a) Informant Henry Mitchell
(b) Address 912 S Bylias

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Balto Nat. Am.
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston Street

19 (a) Date received by local registrar APR 2 1946 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946 at 3 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Stab wound of heart
Stab wound of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-30-46 3 A.M.
(b) Where did injury occur? 1757 Jefferson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbing

23. Signature Benedict Batacchi M.D. Medical Examiner.
Date signed 3-30-46.

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C38936 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 McElderry Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 McElderry Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES V. DERNETZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-7910

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Emma V. Dernetz (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1877

8. AGE: Years	Months	Days	If less than one day
68 yrs.	8	12	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation
11. Industry or business Anchor Post Fence Co.

FATHER
12. Name Vincent Dernetz
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mary J. Stuney - sister
(b) Address 2406 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Filed APR 2 1946 (b) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946, at 8P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 31 1946, and that I last saw h[illegible] alive on March 31 1946.

Immediate cause of death Cerebral Hemorrhage. — Duration 2 days

Due to Arteriosclerotic Cardio-

Due to Vascular disease 8 yrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rosen
Address 2413 E. Monument St. Date signed 4/1/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 N. Ellwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 N. Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED NAOMI TEAT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ James L. Teat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1898

8. AGE: Years	Months	Days	If less than one day
47 yrs.	3	—	hr. min.

9. Birthplace Grasonville, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Horney
13. Birthplace Grasonville, Md.

MOTHER
14. Maiden Name Susan Bryan
15. Birthplace Grasonville, Md.

16 (a) Informant James L. Teat - husband
(b) Address 1211 N. Ellwood Avenue

17 (a) Burial (b) Date thereof 4/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood Cemetery
Location Taylor Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) APR 2 1946 (b)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945 to March 31 1946 and that I last saw h~~er~~ alive on March 31 1946

Immediate cause of death	Duration
Chronic Hypertension	
Due to Arteriosclerotic Cardiovascular Renal Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward B Wolfe
Address 1331 North Ave Date signed 4-7-46

131 A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G38938 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 157 South Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta B. Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Roland Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1912

8. AGE: Years	Months	Days	If less than one day
34	-	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Perry Boston
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Hebron
15. Birthplace Md.

16 (a) Informant Mr. Roland Brown
(b) Address 157 South St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) APR 2 - 1946 (b) Registered by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 29, 1946, at 8:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 19 46 3/29/46 and that I last saw h alive on 3/29/46

Immediate cause of death Uremia

Due to Acute nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Hebron M. D.

Address Date signed 3/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G38939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 Northern Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Johanna Eyn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1865

8. AGE: Years	Months	Days	If less than one day
80	9	7	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Ludwig Doenigsfeld
13. Birthplace Germany

MOTHER 14. Maiden Name Lukke
15. Birthplace Germany

16 (a) Informant Paul Eyn
(b) Address Pasadena, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 7 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md

18 (a) Funeral director Langdon Funeral Home
(b) Address 740 Belair Rd.

19 (a) (Registered by registrar) (b) Huntington Witherspoon, Inc.

APR 2 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1- 1946, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to Fractured Pelvis

Other Conditions Intra-abdominal Hemorrhage
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-31-46 12/2 10:45 P.M.
(b) Where did injury occur? North ave + Park ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by auto.

23. Signature Howard J. Wharton M.D.
Medical Examiner.
Date signed 4-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G38940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Dukeland
(c) Hospital or institution: West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Wabash Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen Goodman.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Leon Goodman
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 5 Nov. '07

8. AGE: Years 39 | Months 4 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife, Trained Nurse

11. Industry or business

FATHER
12. Name Abraham Gonchansky
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Kramer
15. Birthplace Russia

16 (a) Informant Leon Goodman
(b) Address 3411 Wabash Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-46 (month) (day) (year)
(c) Cemetery or crematory Montifore Cem
Location Phila, Pa.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

19 (a) (Date of registration) APR 2 1946 Huntingtown Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 April 1946 at 11:52 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 March 1946 to 1 April 1946 and that I last saw h[illegible] alive on 1 April 1946

Immediate cause of death Respiratory Failure — Duration

Due to Caseous Pneumonic Tuberculosis

Due to —

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Esther A Stacy M. D.
Address West Balto. Gen Hosp Date signed 4/1/46

VS 150

G38941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56B

G38941 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Md. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Broadway St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary K. Simon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1908

8. AGE: Years	Months	Days	If less than one day
37	11	25	hr. min.

9. Birthplace Steubenville Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Barry Hunt
13. Birthplace

MOTHER
14. Maiden Name Don't Know
15. Birthplace Ohio

16 (a) Informant George Simon
(b) Address 310 N Broadway

17 (a) Burial (b) Date thereof 4/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location: Steubenville Ohio

18 (a) Funeral director John A. Myron
(b) Address 600 E. Baltimore St.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

VS 15 APR 2 - 1946 Washington, Hillsdale, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/1946 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1946 to 4/1 1946 and that I last saw h.. alive on 4/1 1946.

Immediate cause of death
Acute Cardiac failure — Duration 1 day
Due to Probable Coronary Thrombosis
Due to Bronchopneumonia

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3/25/46
Major findings of operation: Uterus fibroid
Sm. Appendix
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dudley Chelton
Address Md. General Hosp Date signed 4/1/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38942

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G38942
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Honora C. Sperlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Gerard J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1903

8. AGE: Years	Months	Days	If less than one day
42	8	17	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Edward N. Fiske
13. Birthplace Md.

MOTHER
14. Maiden Name Mary J. Diggins
15. Birthplace Ireland

16 (a) Informant Mr. Gerard J. Sperlein
(b) Address 1636 N. Bond St.

17 (a) Burial (b) Date thereof 4-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) APR 2 1946
Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1946, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1946 to 4-1 1946, and that I last saw her alive on 4-1 1946

Immediate cause of death: Subarachnoid Hemorrhage

Due to: Hypertensive and Arteriosclerotic Heart Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Above

Duration
48 hrs.
4yrs (?)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Russell Pate M. D.
Address Sinai Hosp. Date signed 4-1-46
Baltimore Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G38943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 Dolphin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 Dolphin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Campbell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1906

8. AGE: Years	Months	Days	If less than one day
40	2	1	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frederick Campbell
13. Birthplace Md

MOTHER
14. Maiden Name Hattie Hemsley
15. Birthplace Baltimore, Md

16 (a) Informant Hattie Campbell
(b) Address 537 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date received by local registrar) (b) Huntington Williams, M.D.

APR 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-1946, to 3-29-1946, and that I last saw h[illegible] alive on 3-29-1946.

Immediate cause of death	Duration
Pulmonary Tbc.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 4-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G38944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G38944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Denham Circle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Denham Circle (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Shorter Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Robert Carey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1912

8. AGE: Years 33 Months 8 Days 2 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county and state)

10. Usual Occupation housewife

11. Industry or business home

FATHER
12. Name John E Shorter
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Annie Bailey
15. Birthplace Baltimore, Md

16 (a) Informant Robert Carey
(b) Address 2912 Denham Circle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 APR 2 - 1946 (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946 at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21-1946 to 3-29-1946 and that I last saw h[illegible] alive on 3-29-1946

Immediate cause of death: Carcinoma of Lungs — Duration: 2 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. S. Carey

Address 63 9th Carey St Date signed 4-1-46 M. D.

VS 150

G38945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G38945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Essex Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/1905

8. AGE: Years 40 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Annie Hammond
(b) Address 146 East St.

17 (a) Burial (b) Date thereof 4/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantley ave

19 (a) APR 2 - 1946 Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1946, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, ~~suicide~~ ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pontine Hemorrhage (Brain)
Subdural Hematoma
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shtarelee M.D.
Medical Examiner.
Date signed 3-27-46

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38946

CWK-100281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G38946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4914 O'Donnell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] (WILLIAM BOHLE)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-18-4216 -A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Annie J. Beetz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1871

8. AGE: Years 74 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Gustav Bohle
13. Birthplace Germany

MOTHER
14. Maiden Name Eva ?
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-46 (month) (day) (year)
(c) Cemetery or crematory First Evangelical
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 2 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 31 19 46, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 19 46, to March 31 19 46, and that I last saw him alive on March 31 1946.

Immediate cause of death Cardiac Failure. — Duration

Due to Arteriosclerotic Cardio-Vascular Disease & Decompensation. —

Due to —

Other Conditions Pulmonary Infarct & Embolism. Diabetes Mellitus. —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Faiber, M.D.
M. D.
Address Balt. City Hosps. Date signed 4-1-46

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

638947 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2511 Fait Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Fait Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WILLIAM M GORALSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-1656

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Matilda

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1904

8. AGE: Years	Months	Days	If less than one day
41	7	2	....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Pipe-fitter

11. Industry or business U.S. Coast Guard

FATHER
12. Name Laurence Goralski
13. Birthplace Poland

MOTHER
14. Maiden Name Antonia ?
15. Birthplace Unknown

16 (a) Informant Matilda Goralski - wife
(b) Address 2511 Fait ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705-9 Ann st

APR 2 - 1946 (Date rec'd by Registrar) (b) Huntington Wilkinson Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/46 19.., at 8:50 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 4/2/46

G38948 G38948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Bennington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Bennington Rd
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Eva J. Plecker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel B. Plecker
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 20 1880
8. AGE: Years 65 Months 4 Days 11 If less than one day hr. min.
9. Birthplace Orange Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Coleman
13. Birthplace Orange Virginia

MOTHER
14. Maiden Name Elizabeth Gay
15. Birthplace Orange Virginia

16 (a) Informant Samuel B. Plecker
(b) Address 701 Bennington Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Taylor Ave
18 (a) Funeral director John A. Hogan
(b) Address 601 Fremont Ave
19 (a) APR 2 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/46 19 , at 5 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1917, to 1946, and that I last saw h[illegible] alive on About Mar 19 46
Immediate cause of death Bright's Disease — Duration
Due to Arteriosclerosis
Chronic Renal Infection
Due to Nil otherwise stated
Other Conditions R. Calculus K.D. Removed 1917
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy Arteriosclerosis Pyelonephritis Bil.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Guy L. Hunner M. D.
Address 110 W. Mt. Royal Ave Date signed Apr. 2/46

VS 8

X Hunner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

G38949 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SYDENHAM HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 HOLLINS ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH V. HELMICK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife WILBUR HELMICK
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) JUNE 16, 1918

8. AGE: Years	Months	Days	If less than one day
27 26	9	16	hr. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace WEST VIRGINIA

16 (a) Informant Wilbur Helmick - Husband
(b) Address 921 Hollins ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles H. Schwab
(b) Address 505 N. Mosher St.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 2 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 MARCH 1946, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 MARCH 1946, to 31 MARCH 1946, and that I last saw h.. alive on 31 March 1946.

Immediate cause of death	Duration
Diphtheritic Myocarditis	1 Hour
Due to Diphtheria, tonsillar	5 days
Due to	
Other Conditions Tracheotomy just ante mortem	

(Include pregnancy within 3 months of death)

Date of operation 31 March 1946

Major findings of operation: No obstruction

of autopsy: 1 April 1946

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Katherine Sprunt M. D.
Address Sydenham Hospital Date signed 4-1-46

G38950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V122B

Registered No. G38950

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1187 N. Haven St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Nicol

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Frederick Nicol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29-1886

8. AGE: Years	Months	Days	If less than one day
59	6	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name Martin Schweiger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Henriette Drauny
15. Birthplace Balto. Md.

16 (a) Informant Louis Schweiger
(b) Address 82 30 E Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd

18 (a) Funeral director John D Connelly
(b) Address 418 Eastern Ave Balto 2 Md

19 (a) Date rec'd by Reg. APR 2 1946 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1946 at 5.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 46 to April 1 19 46 and that I last saw h alive on April 1 19 46

Immediate cause of death Cerebral Hemorrhage
a Hypertension

	Duration
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Major findings of operations

of autopsy Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D Connelly M. D.
Address Sinai Hospital Date signed 4-1-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38951 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G38951

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Munshel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 - 1867

8. AGE: Years	Months	Days	If less than one day
79	-	12	hr. min.

9. Birthplace York Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant George Munshell
(b) Address 1119 Brentwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave.

18 (a) Funeral director John J. Donnelly,
(b) Address 418 Eastern Ave. Apt 21 Huntington Terrace, Md.

19 (a) (Date received by registrar) APR 2 1946 Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1946 at 11:20 M.

21. I certify that I took charge of the remains described above, held an Inspection-Examination thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Arteriosclerotic C.V. disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Feldmeier M.D. Medical Examiner.
Date signed 3/31/46

G38952 BALTIMORE CITY HEALTH DEPARTMENT G38952
CERTIFICATE OF DEATH 46E
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5236 Linden Hts. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5236 Linden Heights Ave
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Gertrude Franz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Isidor Franz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1880

8. AGE: Years	Months	Days	If less than one day
65	10	20	hr. min.

9. Birthplace Springfield, Mass.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Patrick Hickey
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Duffy
15. Birthplace Ireland

16 (a) Informant Mrs Isidor Franz
(b) Address 5236 Linden Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Maryland

18 (a) Funeral director Louis Bayer
(b) Address 5005 Park Heights Ave

APR 2 - 1946 (b)
(Date rec'd by Registrar) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946, at 8. A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to Mar 31 1946, and that I last saw her alive on March 30 1946.

Immediate cause of death	Duration
Intestinal Obstruction	3 days.
Due to Carcinoma of Colon	1 yr.
Due to	
Other Conditions Hypertension and myocarditis	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Louis Bayer M. D.
Address 5512 Greenmount Ave Date signed 3/31/46

G38953 — over — BALTIMORE CITY HEALTH DEPARTMENT — G38953 Registered No.

CERTIFICATE OF DEATH

1107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Pembroke Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Blackiston — Charles C. Blackiston, 3rd ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1946

8. AGE: Years	Months	Days	If less than one day
		16 ~~21~~	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles C. Blackiston, Jr.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Grace Merenda
15. Birthplace N. J.

16 (a) Informant Mr. Charles C. Blackiston, Jr.
(b) Address 12 Pembroke Ave., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director E. W. Pomoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) (b)

APR 2 - 1946

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2 1946, at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1946 to 4-2 1946 and that I last saw h/~~his~~ alive on 4-2 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Anoxia	
Due to Pneumonia	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wirt Hollyes M. D.
Address St. Agnes Hosp. Date signed 4/2/46

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G38954

BALTIMORE CITY HEALTH DEPARTMENT ✓ G38954
CERTIFICATE OF DEATH 937 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 W. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FERDINAND KAISER

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-0563813

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Lukas Kaiser
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) July 17, 1872

8. AGE: Years	Months	Days	If less than one day
73	8	13	********** hr. ********** min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation General Chemical Co.
11. Industry or business

FATHER
12. Name Sabasline Kaiser
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Jacob F. Kaiser
(b) Address 2615 W. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Wilbert Sons
(b) Address 1300 Eutaw Place
Turnbaugh Williams, Mgr.

19 (a) APR 2 1946 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 30, 1946, 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1946 to 3/30 1946 and that I last saw h. in alive on 3/30 1946.

Immediate cause of death	Duration
Acute Selective Cardiovascular Disease	
Due to Coronary Thrombosis	1 week
Due to Pulmonary Embolism	1 week
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. A. Weinstock M.D.
Address 4603 Park Hgts. Ave. Date signed

Dr. A.A. Weinstock

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38955 ✓ G38955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 Riverside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Blackeby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Frank Blackeby
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) October 11, 1879

8. AGE: Years	Months	Days	If less than one day
66	5	22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mildred M. Bayne
(b) Address 1004 Riverside Ave

17 (a) Burial (b) Date thereof 4/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Ave

18 (a) Funeral director John F Denny Sons
(b) Address 715 Light St

19 (a) APR 3 1946 (Date received by registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/46 19 , at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15, 1945 to April 2, 1946 and that I last saw h[illegible] alive on April 2, 1946.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Left sided hemiplegia	
Due to (b) Arteriosclerosis	
Due to (a) Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature N. P. Friedman
Address 1319 Light St Date signed 4/2/46

VS 150

G38956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G38956 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1467 Filbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Diamond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/46

8. AGE: Years	Months	Days	If less than one day
		22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Howard Diamond Sr.
13. Birthplace Galax, Va.

MOTHER
14. Maiden Name Francis Siaradzki
15. Birthplace Hibbs, Penna

16 (a) Informant Howard Diamond Sr.
(b) Address 1467 Filbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)
(c) Cemetery or crematory Hibbs Cem
Location Hibbs, Penna

18 (a) Funeral director John L Henry Inc
(b) Address 715 Light St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)
APR 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1946 at 6 55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1946 to 4/2 1946, and that I last saw him alive on 4/2/ 1946

Immediate cause of death	Duration
Aspiration pneumonia	
Due to Cyanosis Stenosis of the newborn.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C E Gonzales M.D.
Address Maryland G. Hospital Date signed 4/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a

Registered No. G38957

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 days

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Allegheny
(c) City or town Lonaconing
(If outside city or town limits, write RURAL and give town)
(d) Street No. Detmold St Box 47
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eunice Jane Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-45

8. AGE: Years	Months	Days	If less than one day
	9 8	17	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William A. Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Mildred Powell
15. Birthplace Texas

16 (a) Informant Mother
(b) Address Detmold St. Lonaconing Md.

17 (a) Removal (b) Date thereof 4-2-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Lonaconing, Md.

18 (a) Funeral director M. Eichorn Funeral Home
(b) Address Lonaconing, Md.

19 (a) APR 3 - 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 1 1946, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1946, to 4-1 1946, and that I last saw her alive on 4-1 1946.

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Chronic bacilar meningitis with extreme cortical atrophy	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Katherine Sprunt M. D.
Address Sydenham Hospital Date signed 4-1-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38958 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Pierce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Watts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife Maisey Watts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-1889

8. AGE: Years 57 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Mutual Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ? Watts
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Jane Parker
15. Birthplace ? Md.

16 (a) Informant James E. Watts-Son
(b) Address 1742 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-46 (month) (day) (year)
(c) Cemetery or crematory Carrols Cemetery
Location Carroll County Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

APR 3 - 1946 (Date rec'd by Local Registrar) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1946, at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1946 to 3-31 1946
and that I last saw h[illegible] alive on 3-31 1946

Immediate cause of death Cerebral hemorrhage — Duration 2dy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address 754 Penn Ave. Date signed 4/4/46

G38959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G38959

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 Ralworth Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Ralworth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katharine S. Rowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh	Divorced

6 (b) Name of husband or wife James Rowe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1877

8. AGE: Years	Months	Days	If less than one day
68	11	18	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Frederick Wiessner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Brömer
15. Birthplace Germany

16 (a) Informant Miss Mildred Tyson
(b) Address 1626 Ralworth Ave.

17 (a) Burial (b) Date thereof 4-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory David Ridge
Location Pikesville Md

18 (a) Funeral director Williamson Coth Co
(b) Address 1212 St Paul Street

19 APR 3 - 1946 Huntington Williamson MD
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946, at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 11 1946, to Apr 1 1946, and that I last saw her alive on Apr. 1 1946.

Immediate cause of death	Duration
Coronary heart disease	3 wks.
(thrombosis)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5715 Bel Air Rd. Date signed 4/1/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G38960

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2042 Mura St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2042 Mura St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Barry

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1862

8. AGE: Years 83 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wilhelm KUEFUS
13. Birthplace Germany

MOTHER 14. Maiden Name (illegible)
15. Birthplace Germany

16 (a) Informant Albert Broadenburger
(b) Address 2042 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 N Paul Place

19 (a) APR 3 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1945 to Apr 1 1946 and that I last saw h[illegible] alive on Apr 1 1946.

Immediate cause of death: Arteriosclerosis C.V. Disease. — Duration: Nov 16 45
Chronic hypertension. — Jan 2 46
Due to Hypertensive Failure. — 4-1-46
Acute Coronary occlusion.
Due to
Other Conditions Nil.
(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operations:
of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. Schumacher M. D.
Address 842 E Fort Ave Date signed 4-2-46

VS 150

X

G38961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G38961 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Linden
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Horton
3 (b) If veteran, name war NO
3 (c) Social Security Account No. NONE
4. Sex F.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. M.
6 (b) Name of husband or wife William Horton
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) OCT. 15 1894
8. AGE: Years 51 50 | Months 5 | Days 17 | If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business AT HOME
FATHER 12. Name JOHN HORNEY
13. Birthplace BALTO. MD.
MOTHER 14. Maiden Name Mary MUELLER
15. Birthplace BALTO. MD.
16 (a) Informant MRS. MAY MUELLER (COUSIN)
(b) Address 3200 EASTERN AVE.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 5/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.
19 (a) APR 3 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946 at 11:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946, to April 1 1946, and that I last saw her alive on April 1 1946
Immediate cause of death Cardiac failure — Duration 1 week.
Due to Hypertensive Cardiovascular Disease.
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation Left pulmonary edema, pleural effusion.
of autopsy H.C.V.D., Cardiac hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature Clarence W. Leyston, Jr. M. D.
Address University Hosp. Date signed 4/2/46

Clayton Williams, M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G38962 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Oakford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Oakford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD (or EDWIN) S. GETTIER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	212-05-8724 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Laura Mae Gettier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1873

8. AGE: Years	Months	Days	If less than one day
72	6	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Hat Maker
11. Industry or business

FATHER
12. Name Edward P. Gettier
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Catherine Shipley
15. Birthplace Md.

16 (a) Informant Mrs. Laura M. Yingling
(b) Address 2703 Allendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 3 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946, at 6:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Apr 1 1946 and that I last saw him alive on Apr 1 1946.

Immediate cause of death	Duration
(a) Chronic Valvular Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Grant H. Raine
Address 1736 Park Ave Date signed 4/2/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G38963 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Westwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Westwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE STACH

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1862

8. AGE: Years 83 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Astrode, Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Miss Emma Emrich
(b) Address 2910 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 3 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1946 to Apr 1 1946 and that I last saw h[illegible] alive on Apr 1 1946.

Immediate cause of death: Chronic Cardiac Occlusion, disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest W. Rabe

Address 1735 Pop[illegible] Date signed 4/1/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38964 ✓ G38964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5703 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5703 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen S Hatch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George C Hatch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/20/ 1851

8. AGE: Years	Months	Days	If less than one day
95	-	13	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name --- Wilkinson
13. Birthplace Unknown

MOTHER
14. Maiden Name Magdalena Combs
15. Birthplace Penna

16 (a) Informant Mrs Hubert Carlburg
(b) Address 5703 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/46 (month) (day) (year)
(c) Cemetery or crematory Union City
Location Pennsylvania

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

APR 5 - 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/46 3:05 PM 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1946 to April 2 1946 and that I last saw h-ex alive on April 2 1946

Immediate cause of death Chronic myocaraditis with myocardial degeneration — Duration 6 weeks
Due to Arteriosclerotic renal disease
Due to Old age
Other Conditions Terminal uremia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold M. D.
Address 4706 Harford Road Date signed 4/3/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38965 ✓ G38965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 N. Payson
(c) Hospital or institution: 15 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 N. PAYSON ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA FISHEL - ALSO KNOWN AS REBECCA ROTTER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex 7

5. Color or race W

6 (a) Single, married, widowed, or divorced DIVORCED

6 (b) Name of husband or wife NOT KNOWN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 64 Months Days If less than one day hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant H. ALPERSTEIN
(b) Address 1912 N PAYSON ST

17 (a) BURIAL (b) Date thereof 4-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E Balto St

19 (a) (b)
(Date rec'd by registrar) Registrar
APR 3 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/46 19 , at 6 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/N 19 46 to 4/1 19 46, and that I last saw her alive on 4/1 19 46.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Schiderd M. D.

Address 2225 Fenden Ave Date signed 4/2/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Z38966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

× ✓ Z38966 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 80
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Meadow Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allene Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1940

8. AGE: Years	Months	Days	If less than one day
6	2	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Benjamins
11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Maryland

MOTHER
14. Maiden Name Madelda
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Dorchester Memorial Park
Location Cambridge, Md.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) April 3, 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1946, at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1946, to 4/2 1946, and that I last saw h[illegible] alive on 4/2 1946

Immediate cause of death Cardio-Resp. failure — Duration

Due to Acute Cardiac Dilatation

Due to Acute Glomerular Nephritis

Other Conditions Hypertension & Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address St Agnes Hosp. Date signed 4/3/46

×

G38967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 3.1

G38967 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 237 N. Durham (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Corrie Lowery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-1893

8. AGE: Years 53 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Waverly, Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lewis Goode
13. Birthplace Va

MOTHER
14. Maiden Name Rosie Jones
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/46 (month) (day) (year)

(c) Cemetery or crematory
Location Waverly Va

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley ave

19 (a) [illegible] (b) [illegible] Huntington Wilmington, N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946 at 9:12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 4-1 1946 and that I last saw h[illegible] alive on 4-1 1946

Immediate cause of death Ruptured of Dissecting aneurysm of aorta — Duration

Due to arteriosclerosis

Due to Hypertension?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Dissecting aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signed Paul Hagerman, Jr. M. D.
Address Johns Hopkins Hosp. Date signed 4/5/46

VS 150

C38968 ✓ C38968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 490963 110a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Robert Xavier Gerstung.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mona
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 6-6-1871

8. AGE: Years	Months	Days	If less than one day
74	9	27	hr. min.

9. Birthplace Rochester N.Y. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Joseph Xavier Gerstung
13. Birthplace Germ.

MOTHER
14. Maiden Name Emma Wissaman
15. Birthplace Ger.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5805 Wakefield Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.
Address Date signed 4/29/46

APR 3 - 1946

VS-150

MEDICAL CERTIFICATION

28. DATE OF DEATH April 1 1946 at 1045 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1946 to April 1 1946 and that I last saw him alive on April 1 1946

Immediate cause of death	Duration
Cardiac failure	6 weeks
Due to Hypertensive Vascular disease & generalized arterio-sclerosis.	112 years
Due to	
Other Conditions Empyema, rt. lower lobe of lung. (Include pregnancy within 3 months of death)	
Date of operation —	
Major findings of operation	
of autopsy As above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Eugene Meyer III
Address Date signed 4/29/46

X

G38969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G38969

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 Roundhill Road
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Roundhill Road
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME: Philip Croutson White

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Janie Nugent
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	28	-- hr. --- min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation: Calculator, Mutual Dept.
11. Industry or business: Racing Association

FATHER
12. Name: John Alexander
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Addie Hoover
15. Birthplace: Baltimore, Maryland

16 (a) Informant: John Austin White
(b) Address: 3702 Clifton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Maryland

18 (a) Funeral director: H. W. Meaty and Son
(b) Address: 805 N. Calvert Street

19 (a) (Date received by local registrar) APR 3 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946 at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1946 to 4/2 1946 and that I last saw h[illegible] alive on 4/2 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 20 Minutes

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J. B. Ballenn
Address: 1036 N. Calvert Date signed: 4/2/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G38970 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Drive & 31st St.

(c) Hospital or institution:
U.S. Marine Hospital, Balto, Md. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 217 Mulberry St.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lok, Pang

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No. 080-16-7825

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Yellow	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1905

8. AGE: Years	Months	Days	If less than one day
40	10	15	hr. min.

9. Birthplace San Francisco, Calif.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Restaurant

FATHER
12. Name Pang Lok
13. Birthplace San Francisco, Calif.

MOTHER
14. Maiden Name ?
15. Birthplace San Francisco, Calif.

16 (a) Informant Records

(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-3-46 (month) (day) (year)

(c) Cemetery or crematory Lomaine

Location Woodlawn

18 (a) Funeral director Stewart Mortuary

(b) Address 108 W. North Ave.

19 (a) (Signature of local registrar) (b) APR 3 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 1946, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 13 1946, to Mar. 30 1946, and that I last saw him alive on Mar. 30 1946

Immediate cause of death Carcinoma of stomach — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/21/46

Major findings of operation: Carcinoma of stomach

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature S. R. Baker

Address S. R. Baker, SURGEON US Marine Hospital, Balto, Md. Date signed 4/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38971 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — 1113 WHATCOAT ST.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL DENNIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	COLORED	MARRIED

6 (b) Name of husband or wife FLORENCE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1888

8. AGE: Years	Months	Days	If less than one day
57	5	1	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name CRAWFORD DENNIS
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name EMMA HANCOCK
15. Birthplace VIRGINIA

16 (a) Informant MARY YOUNG
(b) Address 1416 W. Mulberry Street

17 (a) Burial (b) Date thereof 4-6-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto, Co, Maryland.

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 Penna. Ave.

19 (a) (b)
(Signature of registrar)

APR 3 - 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 - 1946 to 4/2 1946 and that I last saw him alive on 4/2 1946

Immediate cause of death: Cerebral apoplexy — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Brian Roberts, M.D.
Address 3/3 Dunstan Date signed 4/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38972 — 99948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C38972

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore, City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Conkling St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nora Frey or Nore Fray

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-3849

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1876

8. AGE: Years	Months	Days	If less than one day
69	8	30	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Frey
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Tracy
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date rec'd by registrar) (b) Huntingtown, Maryland

VS 150 APR 3 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946 19 , at 7.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15th 1946, to Mar 31 1946, and that I last saw her alive on Mar 31 1946.

Immediate cause of death	Duration
Respiratory Failure.	
Due to Hypertensive & Arteriosclerotic Ht Disease.	
Due to	Resolving
Other Conditions Cerebro-Vascular Accident, Odd. Lobar Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler, Jr. M. D.
Address Balt City Hosp. Date signed 3-31-46

93D

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G38973 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 Normal Avenue
(c) Hospital or institution: 81
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Normal Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael C. Donhauser

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-05-8099

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma Hess
6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): October 31, 189

8. AGE: Years: 54 | Months: 5 | Days: 1 | If less than one day: ##hr. ##min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Manager

11. Industry or business: American Store

FATHER
12. Name: John G. Donhauser
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Helena ?
15. Birthplace: Unknown

16 (a) Informant: George Donhauser (Son)
(b) Address: 1601 Normal Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4430 Belair Rd. Balto; Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) ##### (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

APR 1 = 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st, 1946 at 6.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1946 to 4/1 1946 and that I last saw h[illegible] alive on 4/1 1946

Immediate cause of death	Duration
Heart Failure	24 hr
Due to Bronchio Pneumonia	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Paulton M. D.
Address 3904 Gunnison Blvd Date signed 4/1/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38974 –

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G38974 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution: Mt Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 3912 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Retta Feldman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Female | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Meyer Rubenstein
(b) Address 2122 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1479 E Balto St

19 (a) APR 3 - 1946 (Date rec'd by registrar) Registrar for Baltimore, Md.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2- 1946, at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1946 to April 2-46 and that I last saw [illegible] alive on April 2-46

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 hr
Due to Hypertension Complicated	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Baylin
Address 2040 Eutaw Street Date signed 4/3/46

M. J. Baylin X

G38975 ✓ G38975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143 S Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 S Hilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Evanoock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 - 1885

8. AGE: Years	Months	Days	If less than one day
60	7	18	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace Poland

MOTHER
14. Maiden Name Dont Know
15. Birthplace Poland

16 (a) Informant Frank Kroeko
(b) Address 143 S Hilton St

17 (a) Burial (b) Date thereof Apr 4
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 APR 3 1946 (b)
(Date signed) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/46 19 at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4/46 19 to 4/2/46 19, and that I last saw h alive on 4/1/46 19

Immediate cause of death	Duration
(a) Uremic Myocarditis	Unknown
Due to Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm F Kostka M.D.
Address 1012 Edmondson Ave Date signed 4/3/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G38976 Registered No. 939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Walkling

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6499

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna Walkling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10. 1879

8. AGE: Years	Months	Days	If less than one day
66	10	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Insurance Agt
11. Industry or business

FATHER
12. Name Fred Walkling
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Gotto Stoll
15. Birthplace Germany

16 (a) Informant Ernest Walkling
(b) Address 5002 Cordelia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran Cem
Location near Kingsberg Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) APR 2 (Date Rec'd by Registrar) (b) 1945 Hunting Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2 19 45 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 19 45 to 4-2 19 45, and that I last saw h alive on 4-2 19 45

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic cardio-vascular disease	
Due to	
Other Conditions Pertussis Pleural effusion	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L Rongthal M. D.
Address Sinai Hospital Date signed 4-3-45

VS 150

X

G38977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

G38977
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 N. Broadway
(c) Hospital or institution:
7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rae Shear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abraham -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 | Months | Days | If less than one day: hr. min.

9. Birthplace Rogers New York
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morris Cohen
13. Birthplace Poland

MOTHER
14. Maiden Name Rebecca -
15. Birthplace Poland

16 (a) Informant Abraham Shear
(b) Address 921 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Philad & Hamilton Ave

18 (a) Funeral director Park Lewis Inc
(b) Address 1439 E. Baltimore St

19 APR 3 1946 (Registered by Registrar) (b) Huntington Mills, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2-46 19 at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 19 43 to 3/31 19 46 and that I last saw h[illegible] alive on 3/31 19 46.

Immediate cause of death: Acute cardiac failure — Duration

Due to: Acute Pulmonary Edema

Due to: Ch Arteriosclerosis

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Rosenstein M.D.
Address 733 Augusta St Date signed 4/3/46

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓

Registered No. G38978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3921 Pinkney Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3921 Pinkney Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Eugenie

3 (b) If veteran, name war G
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Isadore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Philip Solotkoff
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-46 (month) (day) (year)
(c) Cemetery or crematory Bonnie Brae
Location Old Nat. Hamilton Ln

18 (a) Funeral director Jenkins Funeral Home
(b) Address 1439 E. Baltimore

19 (a) (Date rec'd by registrar) (b) Registrar

APR 5 1946

Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-1946 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1915 19 to 4/2 1946, and that I last saw h alive on 4/2 1946.

Immediate cause of death Heart Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Ludeman M. D.

Address 2225 Linden Ave Date signed 4/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38979 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 418 Holsen st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Holsen st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L Worch

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Worch | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1870

8. AGE: Years 75 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Lancaster Pa (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Wayne
13. Birthplace Dont know

MOTHER 14. Maiden Name Dont know
15. Birthplace " "

16 (a) Informant Edward Worch
(b) Address 418 Holsen st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Catholic City

18 (a) Funeral director A. Pangallo & Sons
(b) Address 1400 S Bakers st

19 (a) (b) Huntington Williams Registrar
(Date received by registrar) APR 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to April 3, 1946 and that I last saw h her alive on March 15 1946.

Immediate cause of death Cerebral Hemorrhage | Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. O. Friedman M.D.
Address 1319 Eutaw St Date signed 4/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38980 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4304 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WILLIAM T. WOOD

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alice R. Wood
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.): 6/19/1859

8. AGE: Years 86 | Months 9 | Days 12 | If less than one day ********** hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Baltimore & Ohio R.R.

FATHER
12. Name: William Wood
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Maryland

16 (a) Informant: Mrs. Raymond J. Kelly
(b) Address: 4304 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Woodlawn Maryland

18 (a) Funeral director: A. B. Wisheart & Son
(b) Address: 1300 Eutaw Place

19 (a) (Date received by registrar) APR 3 - 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Mar 29 1946 and that I last saw him alive on Mar 29 1946.

	Duration
Immediate cause of death: Acute Cardiac Disturbance	Ondary
Due to: Hypertensive Cardiac Vascular disease	2
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Harry Glassman M. D.
Address 753 W. Fayette Street Date signed Apr 2 1946

Dr. Glassman X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G38981 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 S. Sharp st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 846 S Sharp st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles Dorsey
6 (c) If alive, ~~give age~~ years

7. Birth date of deceased (mo., day, yr.) — 1891

8. AGE: Years 55 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace Calvert Co Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Home

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name Maggie Carter
15. Birthplace Calvert Co. Md.

16 (a) Informant Dolores Cagnina
(b) Address 846 S Sharp st

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 4 1946
(months) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore

18 (a) Funeral director Walter B. Briggs
(b) Address 139 W Hamburg Street

19 (a) APR 3 1946 by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1946 at 12 45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 4/1 1946, and that I last saw her alive on 3/31 1946.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Hypertension	
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunt Williams M.D.
Address 1111 Eutaw Pl Date signed 4/1/46

Huntington Williams, M.D.

G38982

96963-CWK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

78a

G38982 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 5- 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 William Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Weeden Thawley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9-1892

8. AGE: Years	Months	Days	If less than one day
53	4	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Beth. Shipyard

FATHER 12. Name Alexander Thawley

13. Birthplace Md.

MOTHER 14. Maiden Name Frances Storey

15. Birthplace Md.

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director J. W. Cleary

(b) Address 6 E. Fort Ave

19 (a) APR 3 - 1946 (Date received by registrar) Penrington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1945, to Apr. 2 1946, and that I last saw him alive on Apr. 2 1946.

Immediate cause of death Left lower lobar pneumonia — Duration 3 days

Due to Generalized arteriosclerosis — 4 yrs?

Due to Chronic Lead Poisoning — 20 yrs?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.

Address Balto City Hospitals Date signed 4-2-46

VS 150

108

G38983

BALTIMORE CITY HEALTH DEPARTMENT

TM. 97835 **CERTIFICATE OF DEATH** 13B Registered No. G38983

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 S. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd Logan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Sept

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2nd 1902

8. AGE: Years	Months	Days	If less than one day
43	5	19	hr. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Cleaner
11. Industry or business

FATHER
12. Name John Logan
13. Birthplace Ind.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) V (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day)
(c) Cemetery or crematory Loudon Memorial Pk
Location Balto County
18 (a) Funeral director C. Preston Loudenslager
(b) Address 579 Meaher St
19 APR 3 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1946 at 10.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12th 1945 to Apr. 1 1946 and that I last saw him alive on April 1st 1946

Immediate cause of death: Respiratory failure — Duration:

Due to: Pulmonary tuberculosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Baltimore City Hospital Date signed Apr. 3, 1946

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38984 G38984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Taylor Ave. Balto. 14
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Jensen

3 (b) If veteran, name war: World War - I -
3 (c) Social Security Account No. 215-09-4118

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Amelia Jensen
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) Feb. 4, 1888
8. AGE: Years 58 | Months 1 | Days 25 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Attendant in Parking Lot.
11. Industry or business Automobile.

FATHER
12. Name John Jensen
13. Birthplace Norway

MOTHER
14. Maiden Name Anne Greene
15. Birthplace Norway

16 (a) Informant Mrs. Amelia Jensen
(b) Address 2202 Taylor Ave; Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Balto. County Md.

18 (a) Funeral director George Weber & Son.
(b) Address 250 Edmondson Ave.

19 (a) (Signature of local registrar) (b) Registrar
= 1946 Huntington Millware, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1946, at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15, 1946, to April 1st 1946, and that I last saw h.i.m alive on April 1st 1946.

Immediate cause of death Intra abdominal Hemorrhage — Duration

Due to Carcinoma of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 22, 1946

Major findings of operation: Carcinoma of Stomach Ulcerated metastases -

of autopsy Intra abdominal Hemorrhage

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Connor M.D.
Address Mercy Hospital Date signed 4-1-46

Florence P. Connor

G38985

BALTIMORE CITY HEALTH DEPARTMENT

G38985 CERTIFICATE OF DEATH 1448 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 622 S. Monroe St.
(a) Baltimore City, Maryland
(b) Street address 622 S. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 S. Monroe St. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Austria Hungary

3 (a) FULL NAME Frank Sebold.

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Caroline Sebold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 30, 1871

8. AGE: Years 75 | Months - | Days 3 | If less than one day hr. min.

9. Birthplace Austria Hungary. (Town, county, and state)

10. Usual Occupation Sheet metal Worker

11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Austria Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Austria Hungary

16 (a) Informant Henry Sebold
(b) Address 622 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5, 1946 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.

19 [illegible] (Date received) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to 4/2 1946 and that I last saw him alive on 4/2 1946

Immediate cause of death Hodgkins Disease — Duration 9 Mos

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 33 W. Madison Date signed 4/7/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38986

Seufert

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C38986

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Convent of Notre Dame 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. D. Wilfrid Seufert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1900

8. AGE: Years	Months	Days	If less than one day
45 yrs.	4	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Religious

FATHER
12. Name George Seufert
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frances Kalbfleisch
15. Birthplace Baltimore Md.

16 (a) Informant Sr. M. Stan. Keehan
(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof Apr. 4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Glen Arm Md.

18 (a) Funeral director Geo. M. Fritz & Son
(b) Address 811 N. Howard

19 (a) APR 3 - 1946 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946, at 11:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1938, to April 1 1946, and that I last saw h. alive on March 31 1946

Immediate cause of death	Duration
Metastatic Carcinoma	
Due to Skeleton bones	
Due to Carcinoma breast	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation April 1946

Major findings of operation: Carcinoma breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. J. Kirby M. D.
Address 110 E. North Ave. Date signed 4/3/46

G38987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G38987
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Lakeside Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Lakeside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Joseph Mooney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A. Mooney nee Mullinix
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1872.

8. AGE: Years 73 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired, Inspector of
11. Industry or business Baltimore Police Dept.

FATHER
12. Name Roger Mooney
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rosanna Marr
15. Birthplace Ireland

16 (a) Informant Mrs. Mary A. Mooney
(b) Address 1301 Lakeside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Tuttle.
(b) Address 4101 Edmondson Ave.

19 (a) 1946 (b) (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946. at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 to April 1 1946 and that I last saw h[illegible] alive on 3/1/46

Immediate cause of death: Pulmonary Tuberculosis — Duration 1-2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. B. Brady
Address 1403 Park Ave Date signed 4/3/46 M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38988 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County
(c) City or town East Tawas
(If outside city or town limits, write RURAL and give town)
(d) Street No. Star Route
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Hardy, George Franklin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	26	hr. min.

9. Birthplace Deckerville, Michigan
(Town, county, and state)
10. Usual Occupation oiler
11. Industry or business Seafarer

FATHER
12. Name Wm. Hardy
13. Birthplace Canada

MOTHER
14. Maiden Name Lucy Simmons
15. Birthplace Canada

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof April 6-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Port Huron - Michigan

18 (a) Funeral director B. W. Funeral Home Inc.
(b) Address 44 44 York Rd. Towson

(a) Date received by Registrar APR 4 - 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 2 1946, at 5.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1946, to Apr. 2 1946, and that I last saw him alive on Apr. 2 1946

Immediate cause of death	Duration
Respiratory Failure	
Due to Reticulum Cell Lymphosarcoma - generalized	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Robinson M. D.
Address U.S. Marine Hospital Balto, Md. Date signed 4-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 497

Registered No. G38989

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Scott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary C. Kelly

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George R. Kelly

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr 19 1869

8. AGE: Years: 76 | Months: 11 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: Joseph Summers
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Margaret Seymour
15. Birthplace: Baltimore Md

16 (a) Informant: George R. Kelly
(b) Address: 1114 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/6/46 (month) (day) (year)
(c) Cemetery or crematory: Am Catholic
Location: Baltimore Md

18 (a) Funeral director: Fallon Funeral Dir
(b) Address: 1217 W Fayette St

19 (a) APR 4 1946 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6th 1945, to April 2nd 1946 and that I last saw h[illegible] alive on 4-2-1946.

Immediate cause of death: Auricular fibrillation — Duration: 9 months

Due to: Arteriosclerosis — 1 year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Harry Hale, M.D.

Address: 517 Scott St. Date signed: 4/3/1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. 638990

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 E Oliver St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 E Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Bertha L Gorman

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Geo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 28 1865

8. AGE: Years 81 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace: Germany (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Sommer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Wilhelmina (Unknown)
15. Birthplace: Germany

16 (a) Informant: Vincent Gorman
(b) Address: 1804 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)
(c) Cemetery or crematory: Trinity
Location: Baltimore Md

18 (a) Funeral director: Wilhoms Funeral Home
(b) Address: 1319 E Fayette St

19 (a) Date rec'd by Local Registrar APR 4 1946 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1919 to April 2 1946 and that I last saw ... alive on April 2 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1½ days

Due to: Coronary Thrombosis — Duration: 1 week

Due to: Hypertension Arteriosclerosis — Duration: 1 year

Other Conditions: Hemiplegia, Bed sores — Duration: 2 years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [illegible] M. D.
Address 76 Eutaw St Date signed 4/5/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38991 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Green Spring ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Green Spring ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Austin Mc Lanahan

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-3490

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Romaine Le Moyne
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Oct 31 1871

8. AGE: Years	Months	Days	If less than one day
74	5	28	hr. — min.

9. Birthplace Chambersburg Pa. (Town, county, and state)
10. Usual Occupation Banker
11. Industry or business

FATHER
12. Name Dr. Johnston McLanahan
13. Birthplace Chambersburg Pa.

MOTHER
14. Maiden Name Rebecca Austin
15. Birthplace Chambersburg Pa.

16 (a) Informant Mrs Austin McLanahan
(b) Address 4801 Green Spring ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 4 1946 (Month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest Md

18 (a) Funeral director Henry R Jenkins Jr & Co
(b) Address McCulloh - Orchard Sts.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150 APR 4 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 3 1946, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to Apr. 2 1946 and that I last saw h[illegible] alive on Apr. 2 1946

Immediate cause of death Cerebral Hemorrhage — Duration 4 days
Due to Arteriosclerosis & Hypertension.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Murray Fisher M.D.
Address 18 E. Eager St. Baltimore Md Date signed 4/3/46

G38926

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G38926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Mohawk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAH ELLIOTT NIMMO

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1865

8. AGE: Years	Months	Days	If less than one day
80	8	15	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. S. G. Kilmer
(b) Address 7 St. Dunstan's Garth

17 (a) Cremation (b) Date thereof 4/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

1946 Apr 4 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946, at 12:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1st 1946 to Apr 3 1946 and that I last saw h[illegible] alive on Apr 2 1946

Immediate cause of death

Coma
Stomach + Pelvis
Due to CARCINOMA PHARYNX

Duration
hours
12

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. SMINK M. D.
Address 4502 Liberty Hgts Date signed Apr 3

VS 150

G38993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1122B

Registered No. G38993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Belle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary C. Hoffman

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Walter S. Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1871

8. AGE: Years	Months	Days	If less than one day
74	4	22	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Julius H. Brandt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Gebb
15. Birthplace Germany

16 (a) Informant Mr. J. Milton Brandt
(b) Address 304 Gittings Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 4 - 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946, at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 3 1946, and that I last saw her alive on April 3 1946.

Immediate cause of death	Duration
Pulmonary edema	
Due to Cardiac failure	
Due to Post-operative asthenia	
Other Conditions Obstructing volvulus was relieved via Laparotomy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Eavey M.D.
Address University Hosp. Date signed 4/5/46

VS 150

G38994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G38994 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Thomsen Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town W
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Thomsen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph McDaniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 21 1877

8. AGE: Years 68 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace: Loudon Co, Va
(Town, county and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: John Johnson
13. Birthplace: Va

MOTHER
14. Maiden Name: Sarah Vastine
15. Birthplace: Va

16 (a) Informant: Viola McKeymer
(b) Address: 200 E. 102nd St. N.Y. City

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof April 4-1946 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cemetery
Location: A. Ave Co, Md.

18 (a) Funeral director: Robert E Williams
(b) Address: 1515 McCeddery Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

APR 4 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946 at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27-46 19 to 4-1-46 19; and that I last saw h[illegible] alive on 3-30-46 19

Immediate cause of death: Arterial hemorrhage — Duration: 2 days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature: Mary Alma, M. D.
Address: 312 E 23rd N Date signed 4-3-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38995

CHARLES V. ADAMS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 A

Registered No. C38995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 North Calvert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES V. ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-07-3655

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Ramie L. Adams

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1892

8. AGE: Years 54 | Months 2 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Norfolk, Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George V. Adams
13. Birthplace Buffalo, New York

MOTHER
14. Maiden Name Margaret Hughes
15. Birthplace Portsmouth, Va.

16. (a) Informant Mrs. S. B. Tarbington
(b) Address 209 Hannis Ave, Norfolk Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/46 (month) (day) (year)
(c) Cemetery or crematory Elmwood Cem
Location Norfolk Va

18 (a) Funeral director E. M. Lamoreaux
(b) Address 450 Liberty St Norfolk Va

19 (a) APR 4 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/46 19 ____, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, Medical Examiner. M.D.
Date signed 4/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G38996 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Weistock

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Alex.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-02

8. AGE: Years	Months	Days	If less than one day
43 44	7	14	hr. min.

9. Birthplace Mass.
(Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER
12. Name Simon Shapiro
13. Birthplace England

MOTHER
14. Maiden Name Mary Goldstein
15. Birthplace England

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4-5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Fremont Hill Rd.
18 (a) Funeral director Jack Lemp Inc
(b) Address 1439 E. Balto St.
19 (a) APR 4 - 1946 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 3 1946, at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1946 to April 3 1946, and that I last saw h[illegible] alive on April 3 1946

Immediate cause of death	Duration
CONGESTIVE HEART FAILURE	Hours
Due to RHEUMATIC HEART DISEASE with MITRAL STENOSIS & INSUFFICIENCY	10 yrs +
Due to AND AURICULAR FIBRILLATION	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Maxwell Williams M. D.
Address Johns Hopkins Hospital Date signed 4-4-46

Burlington Williams, M.D.

VS 150

G38997 BALTIMORE CITY HEALTH DEPARTMENT G38997
CERTIFICATE OF DEATH 93c Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 E. Balto St
(c) Hospital or institution: 6-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Schwinck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ele
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Geo Schwinck
(b) Address 812 Brooks Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jacob Reuss Inc
(b) Address 1738 E. Balto St

19 (a) (Date rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3- 1946, at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1945 to Apr 3 1946 and that I last saw her alive on Apr 3 1946.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Hypertensive CVHD.	
Due to	
Other Conditions Generalized Arteriosclerosis Chr. Hypertrophic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applefeld M. D.
Address 2511 Reisterstown Date signed 4/3/46

Huntington Williams, MD

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G38993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

G38993 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 No Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 N Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Funk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Bernard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Austria

MOTHER
14. Maiden Name unknown
15. Birthplace Austria

16 (a) Informant Clara Bloom
(b) Address 1516 N Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 APR 4 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-1946 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941, to 4/3 1946.
and that I last saw h[illegible] alive on 4/3 1946.

Immediate cause of death: Coronary Thrombosis — Duration: 3 days
Due to: Cardiac Decompensation — 3 days
Due to: Hypertension — 5 years
Due to: Chronic Hypertrophy
Due to: Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thurlow Cooper M. D.
Address 2201 Eutaw Place Date signed 4/3/46

G38999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G38999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Pearl St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Lemler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Wht	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Austria

MOTHER
14. Maiden Name Anna
15. Birthplace Austria

16 (a) Informant Abe Lemler
(b) Address 512 Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1899 E Baltimore St

19 (a) (Date rec'd by Registrar) (b) APR 4 1946 Registrar

VOID

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946 at 7 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2, 1946 to April 3, 1946 and that I last saw him alive on April 3, 1946

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary thrombosis	
Due to	
Other Conditions Pulmonary edema (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Weiss

Address Sinai Hospital Date signed 4/3/46 M. D.

Huntington Williams, M.D.

X

G39000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G39000 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broad & Greene St.
(c) Hospital or institution: University of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 S. 4th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie M. Guy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
52?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 4 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1946 to Mar 13 1946, and that I last saw him alive on Mar 13 1946.

Immediate cause of death	Duration
Cachexia	
Due to Bilateral Advanced Tuberculosis, Terminal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H. Orr, Jr. M.D.
Address Univ. Md. Hosp. Date signed 3/14/46

VS 150

3394 X

G39001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 D

Registered No. G39001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days) all his

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 North Carrol (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 Name George (GEORGE JACKSON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1-1897

8. AGE: Years 48 05 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 3 1946 Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 4 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/46 19 8:20 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Roberts M.D. Medical Examiner.
Date signed 3/25/46

3383

G3900 2

Roomer - Anchorage Hotel - 612 E. Pratt St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 Registered No. G3900 2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Pratt St. (Roomer)
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James E. Everett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
55			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address.....

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School APR 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address.....

APR 4 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946 at 3:45 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-17-46 at 2:30 A.M.
(b) Where did injury occur? Anchorage Hotel - 612 E. Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Hotel) While at work? No
(d) Means of injury Fall downstairs

23. Signature Robert Lee Gutstein M.D.
Medical Examiner.
Date signed March 17 1946

3392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G39003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G39003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4316 Belvieu Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Konitzky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1881

8. AGE: Years	Months	Days	If less than one day
64	9	19	hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Henry Konitzky
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Stueler
15. Birthplace Germany

16 (a) Informant Etta Konitzky
(b) Address 4316 Belvieu Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 5 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Henry A Smeak
(b) Address 4204 Ridgewood Ave

APR 4 - 1946 (Date rec'd by Registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1946 to April 3 1946 and that I last saw him alive on Apr 2 1946

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. E. Smith M. D.
Address 4309 Liberty Hts Ave Date signed Apr 4

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39004
JL -100016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G39004
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
James Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Nancy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1889

8. AGE: Years	Months	Days	If less than one day
56	9	5	hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Francis Carter
13. Birthplace West Indies

MOTHER
14. Maiden Name Annie Edwards
15. Birthplace West Indies

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St.

19 APR 4 - 1946 (b)
Registered by (Registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19 19 46 to April 1 19 46, and that I last saw him alive on April 1, 19 46.

Immediate cause of death Respiratory Failure — Duration

Due to Pneumonia

Due to

Other Conditions Bronchogenic Ca

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M.D.
M. D.
Address Balt. City Hosp. Date signed 4-1-46

G39005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 D

G39005 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — ORIGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-4134

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
63 62 yrs.			hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Junk Dealer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mary Meads

(b) Address 221 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 Schroeder St

19 (a) APR 4 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1946, at 8 55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.

Date signed 4-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39006
TN. 100219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
75-B

G39006
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Beardley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21 1895

8. AGE: Years	Months	Days	If less than one day
51	1	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfred Addison (D
13. Birthplace ?

MOTHER
14. Maiden Name Martha Hawkins (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 342 N. Schroeder St

19 (a) APR 4 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH April 1st 1946 19 at 10.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28th 19 46 to April 1st 1946.
and that I last saw her alive on April 1 19 46.

Immediate cause of death	Duration
Respiratory Failure	
Due to Rheumatic Heart Disease & Auricular Fibrillation	
Due to Pulmonary Infarction	
Other Conditions Moderate Goitre	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23, Signature Herbert A Farber M.D.
Address Balt. City Hosps Date signed 4-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G39007

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Schroeder St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William G. Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-12-1869

8. AGE: Years 76 | Months 8 | Days 15 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business

FATHER
12. Name Soloman Price
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Percy Price
(b) Address 617 N Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Daniel L Brown & Son
(b) Address 1648 Montgomery St

19 (a) APR 4 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1946, to 3-30 1946, and that I last saw him alive on 3-30 1946

Immediate cause of death	Duration
Myocardial Infarction	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Wilson / J Burlista M. D.

Address 1514 Division St Date signed 4-3 46

X

G39008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G39008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 West Barre (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Stewart Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-5442

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1897

8. AGE: Years	Months	Days	If less than one day
49	9	21	hr. min.

9. Birthplace Belvoir, North Carolina (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Daniel Bowers, Sr.
13. Birthplace N. C.

MOTHER
14. Maiden Name Annie
15. Birthplace N. C.

16 (a) Informant Mrs Elizabeth Haring
(b) Address 628 West Barre Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 6 1946 (month) (day) (year)
(c) Cemetery or crematory Myrtle Grove Cemetery
Location Norfolk, Va. Portsmouth County

18 (a) Funeral director Joseph P. Lively
(b) Address 4000 Mount Street

19 (a) [illegible] (b) Huntington Williams, M.D.
Registrar

APR 4 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/46 19 , at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Carcinoma

Due to

Other Conditions Carcinoma Colon Colostomy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis, M.D.
Medical Examiner
Date signed 4/2/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39009 — BALTIMORE CITY HEALTH DEPARTMENT — G39009

CERTIFICATE OF DEATH 161C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 507- Oxford Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore N (If outside city or town limits, write RURAL and name town)
(d) Street No. 507- Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** (Baby) Leslie Eugene Le' Melle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	

6 (b) Name of husband or wife. March 20 1946
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
2wks	—	14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Raymond Le' Melle
13. Birthplace Texas

MOTHER 14. Maiden Name Marie Parker
15. Birthplace Md.

16 (a) Informant Raymond Le' Melle
(b) Address 507- Oxford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 2316- North Fulton Ave.

19 APR 4 - 1946 (b) (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3- 1946 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1946 to 4/3 1946.
and that I last saw h[illegible] alive on 4/3 1946

Immediate cause of death: (a) Congenital Defect — Duration 5 hrs
Due to: (b)
Due to: (c)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1517 Eutaw Place Date signed 4-4-46 M. D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

639010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 343 S. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 343 S. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma F. Lambert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Col. Elijah F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1849.

8. AGE: Years 96 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Easton, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Neal
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Eva E. Bartels
(b) Address 343 S. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Little
(b) Address 401 Edmondson ave

19 (a) APR 4 1946 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946 at 6h. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 1946 to Apr. 1 1946, and that I last saw h[illegible] alive on Apr. 1 1946

Immediate cause of death: Acute Gastro-Enteritis — Duration

Due to: Infection intramural origin

Due to:

Other Conditions: arterio-sclerosis general

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Macke M. D.
Address 1400 Garrison Blvd Date signed Apr. 3. 46

X

G39011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G39011 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Gwynns Falls Pkwy.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Gwynns Falls Pkwy.
(If rural give location)
(e) If foreign born, how long in U. S. A.? --- years

3 (a) FULL NAME ROBERT P. ARTHUR

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower

6 (b) Name of husband or wife Mary C. Bautz Arthur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1875

8. AGE: Years	Months	Days	If less than one day
70	7	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas J. Arthur
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah A. Dormondy
15. Birthplace Baltimore, Maryland

16 (a) Informant Rev. Robt. P. Arthur, S.J.
(b) Address 3409 Gwynns Falls Parkway

17 (a) Burial (b) Date thereof 4/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Eppner Son, Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 4 - 1946 Vs 1 Municipality for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1946, to April 2 1946, and that I last saw h~~e~~ alive on March 30 1946.

Immediate cause of death	Duration
Carcinoma of cecum	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Medical Arts Bldg. Date signed 4/3/46
M. D.

G39012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

G39012
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo. 21 Days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Light Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Luther Lee Cooksey

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16, 1886

8. AGE: Years	Months	Days	If less than one day
60		15	....hr. ....min.

9. Birthplace Dentsville Md.
(Town, county and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name James A. Cooksey
13. Birthplace Dentsville, Md.

MOTHER
14. Maiden Name Susie E. Cash
15. Birthplace Newberg Md.

16 (a) Informant J. W. Cooksey
(b) Address Dentsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Dentsville, Md

18 (a) Funeral director Hunt & Ryon
(b) Address Waldorf, Md.

19 (a) 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4- 1946, at 5-15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Cerebral Hemorrhage

Due to.....

Other Conditions Generalized arteriosclerosis
Fractured condyles of femurs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 1-18-46 at 22/1 6.20 A.M.
(b) Where did injury occur? Light & Barre
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Mesdera M.D.
Medical Examiner.
Date signed 4-4-46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

APR 4

G39013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G39013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josh Billings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 4 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

3398

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 March 1946 at 5:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Reynolds M.D. Medical Examiner.
Date signed 28 March 46

039014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 039014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1048 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Rucker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address

APR 4 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22- 1946, at 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy + Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shtarzbec M.D.
Medical Examiner.
Date signed 3-23-46

3399

G39015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. G39015

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Redwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Helm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50.			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Loc Johns Hopkins Medical School APR 4 1946

18 (a) Funeral director Commissioner of Health
(b) Address

APR 4 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1946 at 12 30 P.M.

21. I certify that I took charge of the remains described above, held an Insp & inquiry thereof and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed 3-29-46

3400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39016

Dr Ruth 2314 St Paul Ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G39016

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 St Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Collings

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex Male — 5. Color or race White — 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lula E

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Sept 30 1874

8. AGE: Years 71 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)

10. Usual Occupation Ships Chandler Retired

11. Industry or business Self

FATHER 12. Name William Charles Collings

13. Birthplace England

MOTHER 14. Maiden Name Mary Wagner

15. Birthplace

16 (a) Informant Mrs Lula Collings

(b) Address 1016 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director Fulton Cohen

(b) Address 1314 St Paul St

19 ADD 4 1946 (b) (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946; at 3:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 42 to April 1 1946, and that I last saw h alive on April 3 1946.

Immediate cause of death Pneumonia

Cerebral Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W B Hendler M. D.

Address 814 - N Wolfe St Date signed 4/4/46

Huntington Hospital

Dr. Michael
2901 Edmondson Ave.
G39017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

G39017
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward Kaufmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1874

8. AGE: Years 71 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Retired

FATHER
12. Name Johann Urban Kaufmann
13. Birthplace Germany

MOTHER
14. Maiden Name Agatha Schneider
15. Birthplace Germany

16 (a) Informant Agnes Frauz
(b) Address 2744 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 N. Eutaw St. Baltimore, Md.

19 (a) (Date rec'd by registrar) Registrar

APR 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to April 3 1946 and that I last saw h. alive on April 1946

Immediate cause of death	Duration
Myocardial Degeneration due to coronary insufficiency. - Arteriosclerotic type of heart disease with hypertrophy	several years
Due to acute congestive failure	
Due to Generalized arteriosclerosis	
Other Conditions Chronic Bronchitis a bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Michael M. D.
Address 2901 Edmondson Date signed April 3 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35018

TN. 90427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1946

G39018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 5- 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 344 Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Kilmurray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2nd 1862

8. AGE: Years	Months	Days	If less than one day
83	10	1	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Mulrore
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Higgins
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 APR 4 - 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1946, at 6.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26th 1944 to April 3rd 1946 and that I last saw her alive on April 3rd 1946

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Combined Arteriosclerotic & Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice M. Lacy M. D.
Address Baltimore City Hospitals Date signed 4-3-46

VS 150

Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Alessi G39019
6217 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G39019 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Schley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Schley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose M. Saur

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Christian L. Saur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1891

8. AGE: Years	Months	Days	If less than one day
54	9	8 7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Louis Maurer
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schneider
15. Birthplace Germany

16 (a) Informant Mr. Christian L. Saur
(b) Address 4509 Schley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) (Date received by local registrar) (b) Registrar

APR 4 1946 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th, 1946, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-1942 to 4-4-1946, and that I last saw h[illegible] alive on 4/4 1946.

Immediate cause of death	Duration
Uremia	10 days
Cerebral hemorrhage	10 days
Due to Hypertension	
cardio vascular renal disease	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. A. Alessi M. D.
Address 6217 Harford Rd Date signed 4/4/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G39020 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5526 Hill Top Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5526 Hill Top Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Leona G. Whyte

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or ~~wife~~ William D. Whyte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1889

8. AGE: Years	Months	Days	If less than one day
56	6	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Cyrus M. Gardner
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Sappington
15. Birthplace Md.

16 (a) Informant William D. Whyte
(b) Address 5526 Hill Top Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (b) Registrar

APR 4 1946 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946 at 4.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/ 1945 to Apr 1st 1946, and that I last saw h[illegible] alive on Apr 1st 1946.

Immediate cause of death	Duration
Cardiac Coronary Thrombosis	5 days
Due to Epidermoma of Colon & Liver	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D. F. Van Lennep
Address 1 E. Randall Pl. Date signed 4/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 569

G39021 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 AD STREET.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 DAYS.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 DAYS.

2. USUAL RESIDENCE OF DECEASED:
(a) State PENNA. (b) County
(c) City or town YORK.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 W. PRINCESS STREET
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. ~~PERCY ALLEN~~ SENFT (ALVERTA M. SENFT

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife. PERCY ALLEN SENFT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 17, 1905

8. AGE: Years	Months	Days	If less than one day
40	4	18	hr. min.

9. Birthplace PENNSYLVANIA.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE.
11. Industry or business

FATHER
12. Name AMOS RUTTRECHT.
13. Birthplace PENNSYLVANIA.

MOTHER
14. Maiden Name ELIZA HOOVER.
15. Birthplace PENNSYLVANIA.

16 (a) Informant PERCY ALLEN SENFT
(b) Address YORK, PENNSYLVANIA.

17 (a) Burial (b) Date thereof April 8 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York, Penna.
18 (a) Funeral director Leonard J. Rueb
(b) Address 5305 Harford Rd.
19 (a) APR 5 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 4 1946, at 12:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 30 1946 to APRIL 4, 1946, and that I last saw HER alive on APRIL 4, 1946.

Immediate cause of death	Duration
BRAIN TUMOR.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation APRIL 4, 1946.
Major findings of operation: LARGE BRAIN TUMOR - ? MENINGIOMA
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Crawford N. Kirkpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 4-4-46

VS 150

Huntington Williams, Md.

G39022

488601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

G39022 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 N Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Sep.

6 (b) Name of husband or wife Emma May Williams
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 8-10-14

8. AGE: Years	Months	Days	If less than one day
31	7	23	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Williams
13. Birthplace N. C.

MOTHER
14. Maiden Name Ada Mull.
15. Birthplace N C.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7-46 (month) (day) (year)
(c) Cemetery or crematory Shelby, N. C.
Location

18 (a) Funeral director James A. Langley
(b) Address 142 W. 41st St

19 APR 5 1946 (b) Huntington Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1946, to April 3 1946, and that I last saw him alive on April 3 1946

Immediate cause of death: Tuberculous Meningitis — Duration: 2 months
Due to: Secondary to tuberculosis of spine
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: Autopsy 4 Apr 46
Major findings of operation: Tuberculosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Stanton M. D.
Address Date signed 4-7-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G39023

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or wife~~: Frances Hayes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14th 1885

8. AGE: Years 61 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Watchman

FATHER
12. Name William F. Hayes
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Laura McAllister
15. Birthplace Md.

16 (a) Informant John A. Peters
(b) Address 1816 S. Charles St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie A.A.C. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 APR 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946 at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection ~~Autopsy~~ thereon and from the evidence obtained by said ~~Autopsy~~, Inspection or ~~Inquiry~~, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulleneix M.D. Medical Examiner.
Date signed 4-4-46

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G390,24

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G390,24 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2236 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Oscar Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Russia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Wholesale tailor

11. Industry or business

FATHER
12. Name Lazar Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Russia

16 (a) Informant Henry L. Buss
(b) Address 2236 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Hamilton Ave & Belair Rd

18 (a) Funeral director Jack Lurie Funeral Home
(b) Address 1439 E. Baltimore St.

APR 5 - 1946 (Date rec'd) (b) Huntington Williams, M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4-1946, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3-1946 to 4-4-1946 and that I last saw him alive on 4-4-1946

Immediate cause of death	Duration
Massive intracerebral hemorrhage (Right)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of ~~autopsy~~ massive intracerebral hemorrhage

~~of autopsy~~ Carcinoma of bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss, M.D.
Address Sinai Hospital Date signed 4/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39025 (pencil) — BALTIMORE CITY HEALTH DEPARTMENT — G39025 Registered No.

CERTIFICATE OF DEATH

1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Broadway
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosita Bober

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/46

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morton Bober
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Baltimore

16 (a) Informant Morton Bober
(b) Address 2204 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 5 46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Germany Hill Rd

18 (a) Funeral director Sack Lewis Inc
(b) Address 1434 E Baltimore St

19 (a) Date received by Local Registrar 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1946 to April 4 1946 and that I last saw her alive on April 4 1946

Immediate cause of death Peritonitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/31/46

Major findings of operation: Adhesions around duodenum

of autopsy: Peritonitis

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Sinai Hospital Date signed 4-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G35026 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3721 Hillsdale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 Hillsdale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WALTER A. PORTS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Daisy G. Hissey Ports
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 28, 1875

8. AGE: Years	Months	Days	If less than one day
71	2	5	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Produce Dealer
11. Industry or business: Self

FATHER
12. Name: Thomas A. Ports
13. Birthplace: Hampstead, Md.

MOTHER
14. Maiden Name: Eliz. Keene
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Wesley Keene Ports
(b) Address: 3721 Hillsdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) APR 5 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1946, to April 3 1946, and that I last saw him alive on April 2 1946

Immediate cause of death: 1- Coronary Thrombosis. — Duration: 12 hrs.
Due to:
Due to:
Other Conditions: Arteriosclerosis — 5 yrs.
Heart Disease
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Earl L. Thornburg, M.D.
4108 Liberty Hts. Date signed: 4/4/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G3507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK BURGGRAF

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eleanora M. Burggraf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1890

8. AGE: Years	Months	Days	If less than one day
55	4	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Sup't.
11. Industry or business Ellicott Machine

FATHER
12. Name Charles Burggraff
13. Birthplace Baden, Germany

MOTHER
14. Maiden Name Annie Agnes Wagner
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Eleanora M. Burggraf
(b) Address 418 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

vs APR 5 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1946 at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to April 2 1946.
and that I last saw h[illegible] alive on April 1 1946.

Immediate cause of death	Duration
Coronary Thrombosis	5 min.
Due to Arteriosclerosis	6 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Egbert H. Mortimer M.D.
Address 2706 St Paul St Date signed 4/5/46

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C35028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

C35028 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 643 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY A. WEIDNER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-09-3837

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Weidner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1892

8. AGE: Years 53 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Records & Goldsborough

FATHER
12. Name Wm. A. Weidner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie E. Bouldin
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Minnie Weidner
(b) Address 643 N. Bentalou St. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 5 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1946, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944, to Apr. 2, 1946, and that I last saw him alive on Dec. 11 1945.

Immediate cause of death: Coronary Thrombosis — Duration

Due to Hypertensive Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A Kemp

Address 3030 Edmondson Ave. Date signed 4/3/46 M D

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G350,29 ✓ G350,29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Park Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine Ashburner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 19-1874

8. AGE: Years	Months	Days	If less than one day
72	8	14	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles H. Ashburner
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary C. Richardson
15. Birthplace Baltimore, Md.

16 (a) Informant Rosalie Richardson
(b) Address 1931 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1906 Eutaw Place

19 (a) (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

APR 5 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1946, to Apr 3 1946 and that I last saw h[illegible] alive on Apr 2 1946.

Immediate cause of death Uremia sclerosis — Coronary thrombosis — Duration 15 hr 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D H Jones M.D.
Address 2818 St. Paul St. Date signed 4/5/46

Dr Jones X

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

635030

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Avenue
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County none
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8125 Cornwall Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Elmyra Steuart Oglesby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1875

8. AGE: Years	Months	Days	If less than one day
70	8	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Robert S. J. Steuart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elmyra Thompson
15. Birthplace Baltimore, Md.

16 (a) Informant Boyd M. Oglesby
(b) Address 200 Shamanokin St., Harrisburg, Pa.

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery ~~Interment~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

APR 5 - 1946 Hunter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946, to Apr 3 1946 and that I last saw h[illegible] alive on Apr 2 1946.

Immediate cause of death	Duration
Cardiac throm bosis	2 days
Due to Acute Bronchitis	10 days
Due to Arterio sclerosis	Chronic
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 8039 Dunmanway Date signed 4/7/46 M.D.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G350.51 — BALTIMORE CITY HEALTH DEPARTMENT — G350.51

CERTIFICATE OF DEATH

937 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2587 W. Fayette St (Dor.)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2587 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dominic Noon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Anastasia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 12 1870

8. AGE: Years	Months	Days	If less than one day
76	11	21	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER — 12. Name	Patrick Noon
FATHER — 13. Birthplace	Ireland
MOTHER — 14. Maiden Name	Anastasia M Smith
MOTHER — 15. Birthplace	Ireland

(a) Informant Elizabeth Noon
(b) Address 2587 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-46 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Siegel & Tilley
(b) Address 1411 W Fayette

19 (a) (b) Registrar

APR 5 1946

VS 151

Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1946, at 9:40 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions Hypertensive C.V.D.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sulsinger M.D.
Medical Examiner.
Date signed 4/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

639032

HB # 99998

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Ellerp Or Ellerbe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1925

8. AGE: Years	Months	Days	If less than one day
20	7 8	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Ellerp
13. Birthplace Conn.

MOTHER
14. Maiden Name Ella Joyner
15. Birthplace S. C.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4 6 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Balto. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

APR 5 1946 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1946, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18, 1946 to April 4, 1946, and that I last saw h. alive on April 4, 1946.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cardiac Failure	4 wks.
Due to Rheumatic Heart dis. & Pericarditis	6 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. K. Scarborough M. D.
Address 4940 Eastern Ave Date signed 4-7-46

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G350.33

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G350.33 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. Mount St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florrine Cromwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	M

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1909

8. AGE: Years	Months	Days	If less than one day
36	3	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Warmley

13. Birthplace Virginia

MOTHER 14. Maiden Name Martha Ware

15. Birthplace Va.

16 (a) Informant Edward Cromwell

(b) Address 30 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6, 1946 (month) (day) (year)

(c) Cemetery or crematory Elkridge, Location Maryland

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 322 N. Schroeder St

19 (a) APR 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946, to April 3 1946, and that I last saw her alive on April 3 1946

Immediate cause of death	Duration
Rupture of aneurism of Aorta	
producing cardiac failure	
Due to Rupture of aneurism.	
Due to Syphilis	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard J. Cron, M.D.
Address University Hosp. Date signed 4/5/46

VS 150

639034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 639034

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Bass Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
40 39			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Stewart
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Silverman
15. Birthplace Balto. Md.

16 (a) Informant George Stewart
(b) Address 804 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) APR 5 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3 1946, at 6.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1946 to 4-3 1946 and that I last saw him alive on 4-3 1946

Immediate cause of death — Duration

Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mel Blair M. D.

Address 803 W Fremont Ave Date signed 4-4-46

639035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. 639035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3127 Woodland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3127 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Liberato Monaco.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-9070

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife M. Josephine Monaco.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1887

8. AGE: Years	Months	Days	If less than one day
58	3	18	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name Antonio Monaco.
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Jennie T. Monaco.
(b) Address 3127 Woodland Ave.

17 (a) Burial (b) Date thereof 4-6-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Louis Bucci
(b) Address 5015 Park Heights Ave

19 APR 5 - 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1946 at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1946 to April 2 1946 and that I last saw him alive on April 2 1946

Immediate cause of death	Duration
Carcinoma - Prostate gland	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Buckert M.D.
Address 5803 Park Heights Ave Date signed 4/12/46

VS 150

G39036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. G39036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 6
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3624 Elm Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. STANBAUGH

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-3400

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna Ellis Stanbaugh

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1883

8. AGE: Years 63 | Months 2 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Steam Vessel Engineer
11. Industry or business Charles Meyer Co.

FATHER
12. Name Isaac E. Stanbaugh
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Dobbs
15. Birthplace Md

16 (a) Informant Anna E. Stanbaugh
(b) Address 3624 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 8 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Shoemaker & Hannan
(b) Address 11 Chestnut Ave.

19 (a) APR 5 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/46 19 ..... at 9:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner.
Date signed 4/4/46

VS 151

G39037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G39037

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 Crystal Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1718 Crystal Ave (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Friedmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ John Friedmann 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1870

8. AGE: Years 75 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Adam Merbergall
13. Birthplace Germany

MOTHER 14. Maiden Name Alavia ——?
15. Birthplace Germany

16 (a) Informant John Friedmann
(b) Address 1718 Crystal Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Weyforth & Humphreys
(b) Address 662 Harford Rd

19 APR 5 - 1946 (Date Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2- 1946, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1945 to 4-2- 1946 and that I last saw h[illegible] alive on 4- 1946

Immediate cause of death: Chronic Interstitial Nephritis — Duration 3 yrs

Due to:

Due to: Myocardial degeneration — 4 wks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Miller

Address 1500 N Bklvd Date signed 4/7/46

CARMACK

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

039038 T 94 Registered No. 039038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) da a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Church St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Owen Guy Carmack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Virginia Carmack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28-1893

8. AGE: Years 52 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Glen Ridge Pa (town, county, and state)

10. Usual Occupation Storekeeper

11. Industry or business Produce

FATHER
12. Name — Carmack
13. Birthplace Glen Ridge, Pa

MOTHER
14. Maiden Name Emma Mill
15. Birthplace Glen Ridge Pa

16 (a) Informant Mrs Virginia Carmack
(b) Address Hagerstown, Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-5-46 (month) (day) (year)

(c) Cemetery or crematory
Location Hagerstown, Md

18 (a) Funeral director C. M. Suter & Sons
(b) Address Hagerstown, Md

19 APR 5 - 1946 (Date rec'd by registrar) (c) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5- 1946, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard F. Clendenin M.D. Medical Examiner.
Date signed 4-5-46

G39039

BALTIMORE CITY HEALTH DEPARTMENT

AB-100198

CERTIFICATE OF DEATH 160 A

Registered No. G39039

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs. 24min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Green

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28-1946

8. AGE: Years	Months	Days	If less than one day
			12 hr. 24 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Herbert Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Thelma Green
15. Birthplace Baltimore, Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 4/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore City Hospitals

18 (a) Funeral director
(b) Address

19 APR 5 - 1946 Huntington Williams, M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28- 1946, at 3.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28- 1946, to 3-28- 1946, and that I last saw him alive on 3-28- 1946.

Immediate cause of death	Duration
Intra-cranial hemorrhage	8 hrs.
Due to	
Due to	
Other Conditions Pulmonary atelectasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cases be done soon

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Sobee M. D.
Address B. C. H. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G35040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35040 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 Cleveland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Cleveland (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-26-9

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~.

6 (b) Name of husband or wife Cecil C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/21 1873

8. AGE: Years 72 | Months 5 7 | Days 13 2 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Thos E

13. Birthplace Md

MOTHER 14. Maiden Name Amelia

15. Birthplace Md

16 (a) Informant Helen Beyerlein

(b) Address 1124 Cleveland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Frederick Rd

18 (a) Funeral director Edw Faulcon

(b) Address 2359 Wash Ave Hunting Ton Apts, Md

19 (a) (b) Registrar

APR 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1946 at 1:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1945 to 4/4 1946 and that I last saw him alive on March 14, 1946

Immediate cause of death: Coronary occlusion — Duration 5 mins

Due to: Arteriosclerotic Heart Disease — years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar J. Miller

Address 2633 Washington Blvd Date signed 4/4/46 M. D.

63041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

63041 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: University of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Russell Owens

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-24-9665

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	married

6 (b) Name of husband or wife Mary Ida Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1893

8. AGE: Years	Months	Days	If less than one day
53	9	19	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary I. Owens
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-46 (month) (day) (year)
(c) Cemetery or crematory Hopkins Chapel
Location Highland Md

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

19 (a) [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1946, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1946, to 4-4 1946, and that I last saw him alive on 4-3 1946.

Immediate cause of death Heart failure — Duration 6 days

Due to Myocardial damage

Due to Arteriosclerosis

Other Conditions Tuberculosis (x-ray) — Duration 1 year

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Congestive heart failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. L. Crouch M. D.
Address Univ. of Md. Hosp. Date signed 4-4-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

63042

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 123

63042
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE + OLIVER
(c) Hospital or institution: ST JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da
(e) Length of stay in Baltimore (yrs., mos., or days) 71yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County HARFORD CO
(c) City or town BEL AIR.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL P. STINCHCOMB.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWER

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/75

8. AGE: Years	Months	Days	If less than one day
71	-	19	hr. min.

9. Birthplace BEL AIR MD.
(Town, county, and state)

10. Usual Occupation FARM HAND

11. Industry or business

FATHER
12. Name V.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Norman Stinchcomb
(b) Address Bel Air. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7/46 (month) (day) (year)

(c) Cemetery or crematory Mountain Rest Cemetery Church
Location Bel Air Md

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1918 Eutaw Place -

19 (a) (b)
Date received by local registrar APR 5 1946 Registrar Huntington Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 4 1946, at 1.85 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1946 to Apr 4 1946 and that I last saw h[illegible] alive on Apr 4 1946

Immediate cause of death CARDIAC FAILURE — Duration

Due to PERITONITIS

Due to PERFORATED ILIUM.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: PERFORATED BOWEL

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Wells
Address SKDoo HOSP Date signed 4-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39043

HB # 100382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G39043 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Gough ANNIE GOUGH

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter GOUGH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1890 ~~1887~~

8. AGE: Years ~~55~~ 55 | Months 3 | Days 3 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name Croswell? ISSAC
13. Birthplace Md.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 8/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN.
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) APR 5 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 4, 1946 1946 at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4, 1946 to April 4, 1946, and that I last saw h 9r alive on April 4, 1946

Immediate cause of death ? Coronary Occlusion. — Duration

Due to Arteriosclerotic Ht. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Zailer M.D.
M. D.
Address Balt. City Hosps. Date signed 4-5-46

For J. R. Davis, by Howard J. Conaway, M.D. X

(2) 63904 — 63904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BACKS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 N. Bond Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-12

8. AGE: Years 33 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER
12. Name Mat Stewart
13. Birthplace S. C.

MOTHER
14. Maiden Name Mary Richmond
15. Birthplace S. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-46 (month) (day) (year)

(c) Cemetery or crematory
Location Winnsboro, S. C.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Belmont Ave

19 (a) Date received (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1946, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1946 to 4-4 1946 and that I last saw h. alive on 4-4 1946.

Immediate cause of death	Duration
Pulmonary Embolus	Inst.
Due to ? Thrombophlebitis of femoral vein.	
Due to	
Other Conditions Pneumonia Lt Lung Pneumococcus Type I	3 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman D. Stephen M.D.

Address Johns Hopkins Hosp. Date signed 4-7-46

VS 150

100 R

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39045 — BALTIMORE CITY HEALTH DEPARTMENT — G39045

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 S. Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Ann Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL CIERPISZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anastasia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August --, 1860

8. AGE: Years	Months	Days	If less than one day
85	8		hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ---------- Cierpisz
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. John Cierpisz
(b) Address 419 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

vs APR 5 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946 at 4:28 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to April 2 1946 and that I last saw h-- alive on April 1 1946

Immediate cause of death Lobar Pneumonia — Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions Rheumatic arthritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Emil Stankowski M. D.
Address 2879 Eastern Av. Date signed

X

G39086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 D

G39086 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D & A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Walton Mullin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marzene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Grenada, Miss.
(Town, county, and state)

10. Usual Occupation Ship yard worker

11. Industry or business

FATHER 12. Name Robert Walton Mullin

13. Birthplace Miss.

MOTHER 14. Maiden Name Nonny Ella Hill

15. Birthplace Miss

16 (a) Informant Geo. M. Garner, Father

(b) Address Grenada, Miss.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/5/46 (month) (day) (year)

(c) Cemetery or crematory Grenada

Location Grenada Miss

18 (a) Funeral director Hilton Funeral Home

(b) Address 1215 Pont St

19 (a) 1946 (Date rec'd by registrar) (b) Registrar

VS 151

Huntington Williams, MD

130

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4- 1946, at 5 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Glomerulonephritis
Emphysema -

Due to

Other Conditions Chronic bronchitis
Arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Anderson M.D.
Medical Examiner.
Date signed 4-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F Mar 63947 — 63947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Wilhelm St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Wilhelm Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Samuel George Reynolds

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 214-12-0200

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Christina Schalitzky

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3, 1901

8. AGE: Years	Months	Days	If less than one day
45		1	..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name Arthur Reynolds
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary M. Stillwig
15. Birthplace Maryland

16 (a) Informant Mrs Christina Reynolds
(b) Address 1818 Wilhelm St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Harry H. Wilson
(b) Address 4101 Edmondson Ave.

19 (a) Date received by Registrar APR 5 - 1946 (b) Registered by Herbert Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4-1946, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to .....

Other Condition Acute Pulmonary Edema.
Emphysema - 4 d. Anemia Pernicious, 4 d.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 4-4-46

G39018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

G39018 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sinnes Avenue Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kirby

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2. 1876

8. AGE: Years	Months	Days	If less than one day
69	7	26	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Charles Kirby Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Fannie Barton
15. Birthplace Maryland

16 (a) Informant Balto. Co. Welfare Board
(b) Address Towson Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/1946 (month) (day) (year)
(c) Cemetery or crematory St. Paul Reform Church
Location 5600 Cardiff ave. Baltimore
18 (a) Funeral director Howard A. Dill
(b) Address 19 W. Pennsylvania Ave, Towson
19 (a) (Specify city registration district) (b) Huntington Williams, M.D.

APR 5 - 1946

VS 15f

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946, at 5 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed 3-28-46

G39019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G39019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore # 21 - Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Brunswick Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Patrick Ayres

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 - 46

8. AGE: Years | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name John P Ayres
13. Birthplace Va

MOTHER
14. Maiden Name Hazel Coons
15. Birthplace Md

16 (a) Informant John P Ayres
(b) Address 817 Brunswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart.
Location German Hill Rd.

18 (a) Funeral director John J Connelly
(b) Address 418 Eastern Ave Edge 21

19 (a) 5 - 1946 (Filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/46 19 , at 1 P A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3/46 19 to 4/4/46 19 , and that I last saw him alive on 4/4/46 19 .

	Duration
Immediate cause of death Malnutrition & resp. failure	
Due to Cerebral Hemorrhage	3 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Stedham Jr
Address Mercy Hosp Date signed 4/7/46

VS 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39050 BALTIMORE CITY HEALTH DEPARTMENT G39050
CERTIFICATE OF DEATH (45) Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Mazur
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Wid
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-19-73

8. AGE: Years 73 | Months - | Days 16 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name William Mazur
13. Birthplace Poland
MOTHER 14. Maiden Name Josephine ?
15. Birthplace Poland.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozmundt
(b) Address 1930 Eastern Ave.

19 (a) APR 6 1946 (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946, at 8 a.m. DST

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 1946 to April 5 1946 and that I last saw him alive on April 5 1946.

Immediate cause of death: Respiratory failure — Duration:
Due to: Widespread Bronchopneumonia and atelectasis — 3 days.
Due to:
Other Conditions: Carcinoma Stomach
(Include pregnancy within 3 months of death)
Date of operation April 4 1946
Major findings of operation: Extensive carcinoma stomach & jaw
Date of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John D. Elder, Jr. M. D.
Address Johns Hopkins Date signed 4-5-46

VS 150

G39061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193E

G39061 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 577 Laurens St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 577-Laurens (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Louvon Millard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Divorced

6 (b) Name of husband or wife Lillye Millard
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 11, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	22	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Tavern Proprietor
11. Industry or business Entertainment

FATHER
12. Name Lewis Henry Millard
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Florence DeVage
15. Birthplace Baltimore, Md.

16 (a) Informant C. Clarence Millard
(b) Address 747 Park Rd. N.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-46 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Sand. N. Chase & Son
(b) Address 638 N. Gilmor St.

APR 6 1946 (Date received by Registrar) (b) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 April 1946 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1.11.45 19__, to 4.2.46 19__, and that I last saw him alive on 4.1.46 19__.

Immediate cause of death	Duration
Congestive Heart failure	1.1.46
Due to Myocarditis	1.11.45
Due to	
Other Conditions Bronchial Asthma	1.11.45

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Pair M. D.
Address 406 N. Carrollton Ave Date signed 4.4.46

G390-32 G390-32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2248 Sidney Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2248 Sidney Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel F. Peters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Genevieve A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13th 1886

8. AGE: Years	Months	Days 2/2	If less than one day
59	10	21	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Gunther Brewing Co.

FATHER
12. Name Charles Peters
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Richiello
15. Birthplace Italy

16 (a) Informant Mrs. G. A. Peters
(b) Address 2248 Sidney Ave.

17 (a) Removal (b) Date thereof 4/6/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Linwood
Location N. Y.

18 (a) Funeral director William Cook Inc
Address 1217 St Paul St.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

APR 6 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1946, at 10 05 a M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 1944, to 4 PM. 1946 and that I last saw h.i.m alive on 28 March 1946

Immediate cause of death Coronary Thrombosis — Duration 2 yrs.

Due to

Due to

Other Conditions Hypertensive CVR Disease
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Schaefer

Address 5103 Harford Rd Date signed 4/5/46

VS 150

G35053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35053 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Penna Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Penna Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank McCarthy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Millie J. McCarthy
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) May 1862

8. AGE: Years	Months	Days	If less than one day
80	11		hr. min.

9. Birthplace ? Md (town, county, and state)
10. Usual Occupation Cement finisher
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Millie J. McCarthy
(b) Address 1113 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Linden Ave, Ellicott City
(c) 4-6-1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1946 at 6:00 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1946 to 4-3 1946 and that I last saw h in live on 4-3 1946
Immediate cause of death Hypertension Cardio Vascular Disease
Due to
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration
2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. Atwell Jones M. D.
Address 554 Dolphin St Date signed 4-6-1946

VS 150

G35054 (left) G35054 (right)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(832a) Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered carefully and completely. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 N. Eutaw St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 N. Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** L. D. Turnipseed

3 (b) If veteran, name war

3 (c) Social Security Account No. 240-09-4577

4. Sex M

5. Color or race Mulatto Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Vennie Turnipseed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 41 40 Months Days If less than one day hr. min.

9. Birthplace Columbia S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Turnipseed
13. Birthplace S. C

MOTHER
14. Maiden Name Villa —
15. Birthplace S C.

16 (a) Informant Viennie Turnipseed
(b) Address 1000 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)

(c) Cemetery or crematory
Location Columbia S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley Ave

(a) (Date received by Registrar) (b) Huntington Williamsport Md

APR 6 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1946, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1946, to 4/4 1946, and that I last saw h alive on 19

Immediate cause of death Apoplexy — Duration 6 days

Due to Right Sided Pneumonia

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emily Johnston M. D.
Address 908 S. Mary St Date signed 4/4/46

G39055

490908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G39055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Lebanon
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Parkway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Dorothy Newlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-11

8. AGE: Years 34 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business

FATHER
12. Name Howard E. Newlin
13. Birthplace Pa

MOTHER
14. Maiden Name Margaret E. Paddon
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 6/46 (month) (day) (year)
(c) Cemetery or crematory
Location Lebanon Pa

18 (a) Funeral director Philip J. Herwig and Son
(b) Address 2024 Orleans St

APR 6 - 1946 (Date rec'd by registrar) (b) Lucretia Van Hollingsworth M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946 at 9:00 A.M. P

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1946, to April 5 1946, and that I last saw h[illegible] alive on April 5 1946.

	Duration
Immediate cause of death: Respiratory failure.	
Due to: Extensive Carcinoma of Cervix	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. E. Speed M.D.
Address Johns Hopkins Hosp. Date signed 4/6/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

035056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94B

035056 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 S Schroder
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Schroder St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alfonso Andreone

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-5689

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Albert. Andreone
(b) Address 118 S Schroder st

17 (a) Burial (b) Date thereof 4-4-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd

18 (a) Funeral director Joseph Kasmisken
(b) Address 602 Washington Blvd

19 (a) (b)
(Date received by registrar) Registrar

APR 6 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/46 19 , at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1946, to 4-4-1946, and that I last saw h/xx alive on 4/2 19 46.

Immediate cause of death — Duration

Acute cardiac dilatation — 3 hr.

Due to Congestive Failure — 3 yrs.

Due to Hypertension — 3 yrs.

Other Conditions

(Includes pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Colao M. D.
Address 4 N. Fulton Date signed

Huntington Williams M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G390-57 / 94a

Registered No. G390-57

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 ALAMEDA AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Murphy LOMAX

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-09-3483

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Margaret Elizabeth Lomax

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1880

8. AGE: Years 65 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace St. Mary's Co., Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business N. Hess Sons

FATHER
12. Name Francis Henry Lomax
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Almira Jackson
15. Birthplace St. Mary's Co., Md.

16 (a) Informant Mrs. Annie Walmsley
(b) Address 2701 Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 6 - 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946 at 11 10 A.M.

21. I certify that I took charge of the remains described above, held an INSP ING. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 4-5-46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39058 G39058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 3
(d) Street No. 1354 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LAURETTA (Loretta) ESTER ARNOLD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	wh	M

6 (b) Name of husband or wife Richard J. Arnold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1901

8. AGE: Years	Months	Days	If less than one day
44	7	16	hr. min.

9. Birthplace Pa. (Pen Argyl) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Guthrie
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Mr. Richard J. Arnold
(b) Address 1354 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 6 - 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4-46 19 , at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1946, to 4-4-1946, and that I last saw h[illegible] alive on 4-4-1946

Immediate cause of death	Duration
Pulmonary oedema	
Due to anemia + blood loss	
Due to Cerrhosis of liver	
Other Conditions Oesophageal varices & internal hemorrhoids	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hosp. Date signed 4-4-46

VS 150

X

G35059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2448 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	405-10-8885

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie Jones
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec-6, 1886

8. AGE: Years	Months	Days	If less than one day
59 60	3	27	hr. min.

9. Birthplace Harford County, Md
(Town, county, and state)
10. Usual Occupation Track Fore Engn
11. Industry or business Maryland-Pa. R.R.

FATHER
12. Name Wm. H. Jones
13. Birthplace Harford County, Md

MOTHER
14. Maiden Name Elizabeth Jourdan
15. Birthplace Harford County, Md

16 (a) Informant Minnie Jones
(b) Address 2448 Maryland Ave

17 (a) Burial (b) Date thereof April 6, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore Md
18 (a) Funeral director Leonard D. Covington
(b) Address 21 W 25th ST.
19 (a) APR 6 - 1946 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1946 at 8 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-3-46

X

G35060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G35060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1X49 N Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1X49 N Carey St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME James Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 1909

8. AGE: Years	Months	Days	If less than one day
36	10	11	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Bailey
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Griffin
15. Birthplace Va.

16. (a) Informant Mary Bailey
(b) Address 1X49 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/46 (month) (day) (year)
(c) Cemetery or crematory Gibbons
Location Md

18 (a) Funeral director Wed. H. Kelson
(b) Address 1303 Presstman St

19 (a) (Date received by registrar) (b) Registrar

APR 6 - 1946

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 5 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1946, to Apr 5 1946, and that I last saw him alive on Apr 4 1946.

Immediate cause of death Cardio Vascular Renal Disease — Duration 6 mo's

Due to Hypertension — Duration 2 mo's

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 724 Penna Ave Date signed 4/7/46

G39061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G39061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Marlborough Apts.
(c) Hospital or institution:
14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA M. JACOBI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Marcus Jacobi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1872.

8. AGE: Years	Months	Days	If less than one day
73	11	27	hr. min.

9. Birthplace Washington, N.C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob Rosenthal,
13. Birthplace Germany.

MOTHER
14. Maiden Name Ida Rosenthal,
15. Birthplace Germany.

16 (a) Informant Mr. Albert R. Marks,
(b) Address Temple Garden Apts.

17 (a) Removal & Burial (b) Date thereof 4/6/46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Grove
Location New Bern, N. C.

18 (a) Funeral director Edward Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 APR 6 - 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th. 1946, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 , to April 5 1946, and that I last saw h~~er~~ alive on April 5 1946.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Coronary artery disease	6 yrs
Due to Arteriosclerosis	6 yrs
Other Conditions Had an attack of coronary thrombosis 6 years ago	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick Lentz
Address TEMPLE GARDEN APTS. Date signed 4/6/46 D.

X

Dr. Harbold

G3902 BALTIMORE CITY HEALTH DEPARTMENT G3902

CERTIFICATE OF DEATH 1210 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Oakcrest Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Oakcrest Avenue (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Thomas A. Duncan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lena Ray Duncan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1873

8. AGE: Years	Months	Days	If less than one day
72	7	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Andrew Duncan
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Heaps
15. Birthplace Md.

16 (a) Informant Mrs. Lena Ray Duncan
(b) Address 3002 Oakcrest Avenue 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 APR 6 - 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1944 to April 3 1946 and that I last saw him alive on April 1 1946.

Immediate cause of death	Duration
Coronary occlusion	4 hours
Due to Coronary sclerosis	
Due to Arteriosclerotic hypertensive cardiovascular renal disease	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold M. D.
Address 4706 Harford Road Date signed 4/5/46

GB90633 KERSHAW. BALTIMORE CITY HEALTH DEPARTMENT 55E GB90633

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8036 Phila Road
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8036 Phila Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arthur J Kershaw

3 (b) If veteran, name war

3 (c) Social Security Account No. 208-10-3112

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Sarah S. Kershaw
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb 12 - 1884

8. AGE: Years	Months	Days	If less than one day
62	1	20	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Brass Moulder
11. Industry or business Sparrows Point

FATHER
12. Name Arthur Kershaw
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joan Elizabeth Sutcliffe
(b) Address 8036 Phila. Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Maryland

18 (a) Funeral director Thos. J. Keighley Inc
(b) Address 1600 Hanover St

19 (a) APR 6 - 1946 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 2, 1946 to April 4 1946, and that I last saw him alive on April 2 1946.

Immediate cause of death Cachexia, Sarcoma

Duration

Due to Generalized Carcinomatosis

Due to Primary Site Unknown

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Wenz, M.D.
Address Sinai Hospital Date signed 4/7/46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G39064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Toone Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME IRVING FISCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Rose A. Koppleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1902

8. AGE: Years 43 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business Sparrows Pt. Md.

FATHER
12. Name Herman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Fredericka Leichner
15. Birthplace Baltimore

16 (a) Informant Wife
(b) Address 3306 Toone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) APR 6 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/46 19..... at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 4/4/46

G39065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

Registered No. G39065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp. S. Penna
(c) Hospital or institution: University Hosp. 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Williams St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Maria D'Antonio

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/14/1945

8. AGE: Years	Months	Days	If less than one day
	8	21	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Modesto De Antonio
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Van Detta
15. Birthplace Latrobe Pa.

16 (a) Informant Maria Van Detta
(b) Address 1123 William St.

17 (a) Burial (b) Date thereof 4/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway Anne Arundel Co.
18 (a) Funeral director Elizabeth Hart Funeral
(b) Address 115 E. West St.
19 (a) Filed APR 6 1946 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946 at 8 35 P M
21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1946 to April 4 1946 and that I last saw her alive on April 4 1946 8 20 A
Immediate cause of death Cerebral Embolism (pulmonary) failure (pulmonary) — Duration
Due to Pneumonia
Due to Embolism
Other Conditions Hypertension; Congestion of Brain, Kidneys.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. E. McCurdy M. D.
Address University Hosp. Date signed Apr. 4, 1946

VS 150

639066

BALTIMORE CITY HEALTH DEPARTMENT

HB# 92782

CERTIFICATE OF DEATH 93D

Registered No. 639066

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 16 17-3
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 849 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ananias Dameron

3 (b) If veteran, name war

3 (c) Social Security Account No. 1744 218-10-7742

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1875

8. AGE: Years	Months	Days	If less than one day
70	8	17	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Luke Dameron (d)
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Jane
15. Birthplace Va.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (Date rec'd by registrar) (b)

APR 6 - 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946 at 2:55P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26, 1946 to April 1, 1946 and that I last saw h im alive on April 1, 1946

Immediate cause of death: Hypertensive Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23, Signature O. Rausch M.D.
Address Balto City Hospitals
M. D.
Date signed 4.1.46

Huntington Williams, M.D.

G39067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G39067 Registered No.

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4713 Falls Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4713 Falls Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rachel A. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Widow

6 (b) Name of husband or wife Simon P. Scott Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1870

8. AGE: Years	Months	Days	If less than one day
75	3	10	hr. min.

9. Birthplace Lancaster County, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Washington Brown
13. Birthplace Pa.

MOTHER
14. Maiden Name Nancy Jay
15. Birthplace Pa.

16 (a) Informant Lydia Frances
(b) Address 4713 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-46 (month) (day) (year)
(c) Cemetery or crematory Bare Hill
Location Balto. County, Md.

18 (a) Funeral director Joseph L. Locke
(b) Address 1364 N. Central Ave.

19 (a) [illegible] (Huntington Hilleary)

APR 6 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1946 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1946 to Apr 4, 1946 and that I last saw her alive on Apr 4th, 1946

Immediate cause of death: Asphyxia Duration
Obstruction 7 hrs

Due to Endocarditis & 2 yrs
senile debility

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury family

23. Signature D. G. Scott M. D.
Address 354 N. Bielleet Date signed 4-5-46

VS 150

635068
490682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

Registered No. 635068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-16

8. AGE: Years	Months	Days	If less than one day
30.	4	20	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sam Watson
13. Birthplace Va

MOTHER 14. Maiden Name Lillie Griffin
15. Birthplace Va

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brightberry Ave

APR 6 1946 (b) Huntingtown Maryland
(Registered by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946 at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1946 to April 4 1946 and that I last saw h[illegible] alive on April 4 1946

Immediate cause of death Resp. failure

Due to Anemia

Due to Chr. nephritis

Other Conditions Pneumonia?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Nothing grossly

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin Grunch M. D.

Address J H H Date signed 4-8-46

VS 150

C39069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C39069

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 - 15th St. N.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Fannie Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28, 1898

8. AGE: Years	Months	Days	If less than one day
48	-	8	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-46 (month) (day) (year)
(c) Cemetery or crematory
Location Washington D. C.

18 (a) Funeral director Mrs. Frances R. Hensley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Funeral Home

APR 6 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5-1946 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5-1946 to 4-5-1946 and that I last saw h... alive on 4-5-1946

Immediate cause of death: Brain Tumor, left hemisphere - (Duration)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed

G35070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G35070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 E. Birckhead St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 E. Birckhead Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM D. CONRAD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Martha E. Pfeiffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/7/1871

8. AGE: Years	Months	Days	If less than one day
75	0	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Balto. Paper Box Co.

FATHER
12. Name Louis F. Conrad
13. Birthplace Germany

MOTHER
14. Maiden Name Anna D. Schmidt
15. Birthplace Germany

16 (a) Informant Family
(b) Address 120 E. Birckhead St.

17 (a) Burial (b) Date thereof 4/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director J. L. McCurley
(b) Address 130 E. Fort Ave.

19 (Date rec'd by registrar) APR 6 - 1946 Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/46 at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1945 to April 5, 1946, and that I last saw h[illegible] alive on April 5, 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Chronic Myocarditis.	
Due to	
Other Conditions Arterial Sclerosis?	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature N. L. Friedman M. D.
Address 131 S. Clifton St. Date signed 4/6/46

VS 150

X

G39071 KIRCHNER G39071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 Clarenion Hilton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Clarenion Hilton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Jeanette Kirchner (KIRCHNER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1857

8. AGE: Years	Months	Days	If less than one day
88	4	22	hr. min.

9. Birthplace Shady Side A.A.C. Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Solon Avery

13. Birthplace Patuxent Anne Arundel Co. Md

MOTHER 14. Maiden Name Cynthia Woodard

15. Birthplace Galesville Md.

16 (a) Informant Ralph Kirchner

(b) Address 3110 Clarenion Hilton Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 8 46 (month) (day) (year)

(c) Cemetery or crematory Carretonga

Location Shady Side Md.

18 (a) Funeral director T. C. Hensley & Son

(b) Address Galesville Md.

19 APR 6 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 46 19 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 April 1946 to 7 April 1946; and that I last saw her alive on April 7 1946.

Immediate cause of death Generalized arteriosclerosis

Due to Senility

Due to —

Other Conditions Sprained left ankle and Left Shoulder.
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations none

of autopsy: none

Duration (estimated: 2 & 0 yrs) (Gen.: 20-40 yrs)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3-31-46 at 9 M
(c) Where did injury occur? 3110 Clarenion Avenue (City or town) Hilton (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Collapsed on bathroom floor.

23. Signature Edward L. Moz M. D.

Address 7329 Harford Rd. Date signed 6 April 46

Howard J. Mendelsohn, M. D.

VS 150

G38072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G38072

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 E 36th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town York.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hill Crest York R.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Lewis.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17-1884

8. AGE: Years	Months	Days	If less than one day
~~About~~ 61	11	20	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name F. Schaffer
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant J. H. Schandler
(b) Address York Pa

17 (a) Burial (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location York Pa

18 (a) Funeral director John G Moran
(b) Address 2000 Baltimore

19 (a) APR 6 1946 Huntington Williams
(Date rec'd) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 930 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to April 6 1946 and that I last saw her alive on April 5 1946

Immediate cause of death: Adenoma of Breast — Duration

Due to

Due to

Other Conditions Anemia Asthenia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.

Address 300 Shannon Dr Date signed 4/6/46

(OVER)

G39073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G39073 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 McHenry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A. Staubitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elmer L. Staubitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1893.

8. AGE: Years	Months	Days	If less than one day
52	9	26	hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Adam J. Voeth
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Miller
15. Birthplace Germany

16 (a) Informant Elmer L. Staubitz
(b) Address 1917 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8/46. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Henry H. Kieffer.
(b) Address 4101 Edmondson Ave.

APR 9 - 1946 (Date rec'd by registrar) (b) Huntington Ma[illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4/46. 19 ; at 9.4. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945 to Apr 4 1946, and that I last saw h[illegible] alive on Apr 3 1946.

Immediate cause of death Carcinoma of Sigmoid — Duration 6 Mo

Due to

Due to

Other Conditions General Metastases
(Include pregnancy within 3 months of death)

Date of operation Oct 25, 1945

Major findings of operation: Carcinoma of Sigmoid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 7[illegible] Medical Arts Date signed 4/5/46

G39074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G39074 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Union Memorial Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 W. Franklin St. City 1
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ellen Cooper Henshaw

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Ellen C. Henshaw
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) August 6, 1885

8. AGE: Years	Months	Days	If less than one day
60	7	30 29	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Artist
11. Industry or business

FATHER 12. Name Arthur Henshaw
FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Mary Cooper
MOTHER 15. Birthplace Unknown

16 (a) Informant Mrs. Ellen C Henshaw
(b) Address 208 W. Franklin St. City 1

17 (a) Cremation (b) Date thereof Apr 8 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory London
Location Baltimore Md.

18 (a) Funeral director Henry W. Jenkins & Bro
(b) Address N. Calvert & Orchard Sts.

19 (c) Date received by registrar APR 7 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946, at 8:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to April 5 1946 and that I last saw h Ilive on April 5 1946.

Immediate cause of death: Respiratory Failure — Duration

Due to Intestinal Obstruction

Due to Carcinoma of Splenic Flexure of the Large Intestine

Other Conditions: Widespread metastases
(Include pregnancy within 3 months of death)

Date of operation April 1, 1946

Major findings of operation: Carcinoma of Large Intestine

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice D. Lieber M. D.
Address Union Memorial Hosp Date signed April 5, 1946

W.H. Hubbel M.D. X

G39075 G39075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3413 Ravenwood avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Ravenwood avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? --- years

3 (a) FULL NAME CHARLES MILSKE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ida Bosse Milske
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1866

8. AGE: Years	Months	Days	If less than one day
79	6	8 2[illegible]	hr. min.

9. Birthplace: Richmond, Virginia (Town, county, and state)
10. Usual Occupation: Retired Contractor &
11. Industry or business: Builder

FATHER
12. Name: Charles Milske
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Robert Browning
(b) Address: 3413 Ravenwood avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location:

18 (a) Funeral director: Chas. J. Cramer & Son Inc
(b) Address: 118 N. Mt. Royal Ave
(a) Date received: APR 7 1946 (b) Registrar's signature for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1943, to April 4, 1946 and that I last saw him alive on April 3 1946.

Immediate cause of death: Carcinoma of Stomach — Duration —

Due to:

Due to:

Other Conditions: Arteriosclerotic Cardio-Vascular Disease

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J. B. Stevens
Address: 3403 Eastman Ave Date signed: 4/5/46

VS 8

Please write plainly, with ink. Fill in all items. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G39076

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 ds
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Scofield

3 (b) If veteran, name war: ?

3 (c) Social Security Account No.: ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1861

8. AGE: Years	Months	Days	If less than one day
84	10 9	5	hr. min.

9. Birthplace Connecticut
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Orlando Scofield
13. Birthplace Connecticut

MOTHER
14. Maiden Name
15. Birthplace England

16 (a) Informant Hospital Record
(b) Address

17 (a) Removal (b) Date thereof Apr 7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Bethel Conn.

18 (a) Funeral director Henry N. Jenkins Sons Co
(b) Address Mulberry & Orchard Sts

19 (a) Date APR 7 1946 (b) Signature and title for Williams, M. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19, 1946 to April 6 1946, and that I last saw him alive on April 6 1946.

Immediate cause of death: Cardio-respiratory failure

Due to possible broncho-pneumonia

and pyelitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul B. Tavel, M.D.

Address Union Memorial Hosp. Date signed 4/6/1946

X

G39077 ✓ G39077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Sq. Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5dy.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Evans Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby ~~Boy~~ Sparks.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31-46

8. AGE: Years | Months | Days 5 6 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Glen Sparks
13. Birthplace W. Va.

MOTHER
14. Maiden Name Alma Clayton
15. Birthplace N. Carolina

16 (a) Informant Glen J. Sparks.
(b) Address 1020 Evans Ways.

17 (a) Removal (b) Date thereof 4/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Roxboro.
Location N. Carolina

18 (a) Funeral director Wm Cook Inc.
(b) Address 212 St Paul St

19 (a) 4-7-1946 (b) Registrar
(Filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1945 to April 6 1946, and that I last saw him alive on April 6 1946

Immediate cause of death Prematurity.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Coral Gordon M. D.
Address 2201 W. North Ave Date signed 4-7-46

G39078 BALTIMORE CITY HEALTH DEPARTMENT G39078
CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. Fayette & Calhoun. (If rural give location)
(e) Citizen of foreign country? No 1020 Evans Way (Ward No.)
If yes, name country

3 (a) FULL NAME Baby Sparks.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar 31-1946
8. AGE: Years | Months | Days 5 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Glenn Sparks.
13. Birthplace
MOTHER 14. Maiden Name Sparks Alma.
15. Birthplace North Carolina.
16 (a) Informant Glenn Sparks
(b) Address 1020 Evans Way.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/6/46 (month) (day) (year)
(c) Cemetery or crematory Roxboro.
Location North Carolina
18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.
19 (a) (Date rec'd by registrar) APR 7 - 1946 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946, at M
21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1946 to April 5 1946
and that I last saw him alive on April 5 1946

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Carol Gordon M. D.
Address 2201 W North Ave Date signed 4-5-46

X

G35073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G35073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.H.
(b) Street address
(c) Hospital or institution:
Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lennie Sweeny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Halifax Va.
(town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joe Sweeney
13. Birthplace Va.

MOTHER
14. Maiden Name Lennie Stephens
15. Birthplace Va

16 (a) Informant Joseph Sweeney
(b) Address 631 Paca Street

17 (a) Burial (b) Date thereof 4/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Halifax [illegible]
Location Va.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

APR 7 1946 Huntington Williams MD
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1946 at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. J. Salvinski M.D.
Medical Examiner.
Date signed 4/7/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

491071 C35080 BALTIMORE CITY HEALTH DEPARTMENT ✓ C30080

CERTIFICATE OF DEATH 35

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 N. Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Faust.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-44

8. AGE: Years	Months	Days	If less than one day
1	10	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Willie Faust
13. Birthplace Va

MOTHER 14. Maiden Name Pola Huff
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof Apr 6 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary.
Location

18 (a) Funeral director Adolphus Holstead
(b) Address 918 Light St

19 (a) APR 7 - 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH April - 5 1946, at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April - 2 1946, to April - 5 1946 and that I last saw him alive on April 5 1946

Immediate cause of death Bronchopneumonia — Duration

Due to Post measles

Due to

Other Conditions Pleural effusion right

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George S Palmer
Address Johns Hopkins Hosp Date signed 4/5/46

VS 150

G39081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G39081

Registered No. 82a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4608 Belvieu Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 Belvieu Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie May Davidson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William T. Davidson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10, 1874

8. AGE: Years	Months	Days	If less than one day
72	2	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jerome Owens
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Eliza Bolton
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Laurence Silver
(b) Address 4608 Belvieu Ave.

17 (a) Burial (b) Date thereof April 8, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Laurason
(b) Address 4510 Liberty Heights Ave.

4 9 1946 Huntington Williams, Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946, at 6.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1946 to 4/4 1946, and that I last saw her alive on 4/4 1946.

Immediate cause of death Cerebral hemorrhage — Duration 3 hours

Due to Hypertension

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis V. Blum, M. D.
M. D.
Address 2310 Eutaw Place Date signed

G39082

BALTIMORE CITY HEALTH DEPARTMENT ✓G39082

CERTIFICATE OF DEATH 92 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered, or satisfactory reasons given for omission. Use terms of exact meaning. Do not use abbreviations or terms of common understanding. Be sure to give the causes of death clearly and legibly. Physicians: please write the cause of death in such terms as will indicate the disease originating the fatal train of morbid processes, and not the mode of dying, such as heart failure, asphyxia, anemia, etc. Be sure to fill in the time interval between the onset of each and death. Operations should be stated only when performed for some condition affecting the cause of death. Statements of duration of residence and of age are required. Even approximate statements are accepted when definite statements cannot be obtained. Infant deaths should be reported with the same care as deaths of persons of mature age. Stillbirths should be reported to the Bureau of Vital Statistics, but not recorded as deaths. Fetal dea

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

035033

BALTIMORE CITY HEALTH DEPARTMENT 946-035033

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 Presbury St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2011 Presbury (If outside city or town limits, write RURAL and give town)
(d) Street No. Rear (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM Z. LEVINE

3 (b) If veteran, name war WORLD WAR I

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife LILLIAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation PRINTER

11. Industry or business

FATHER
12. Name AARON
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ESTHER
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-7-46 (month) (day) (year)
(c) Cemetery or crematory SHAAREI TFILOH
Location WINDSOR MILL RD.

18 (a) Funeral director VOGEL LEWIS INC
(b) Address 1439 E. BALTO ST

19 (a) 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4- 1946 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 4/4 1946 and that I last saw him alive on 4/4 1946

Immediate cause of death Coronary Occlusion — Duration 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Saraubin M.D.
Address 2128 W. North Ave Date signed 4/6/46

VS-180

G35084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G35084 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2713 Oswego Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 Oswego Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Sacks

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1880

8. AGE: Years 65 | Months 3 | Days 18 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Adolphy
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Harry Sacks
(b) Address 2713 Oswego ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-46 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Balto St

19 (a) 1946 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946, at 2:00 PM

21. I certify that death occurred on Feb. 25 1946 about April 1 1946 and that I last attended deceased from him April 6 1946 and that I last saw him alive on April 6 1946

Immediate cause: Respiratory Failure — Duration:
Due to: Heart Failure
Due to: Coronary Heart Disease — 5 yrs.
Other Conditions: None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel V. Troyer M. D.
Address 3431 Pk Heights Ave Date signed April 6, 1946

(over)

G39085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G39085

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: W. B. & H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt - Hilton Court Apts
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Dorithan Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Zitlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			10½ hr. min.

9. Birthplace W. B. & H
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Paul Zitlin

13. Birthplace Balt Md

MOTHER 14. Maiden Name Mildred Bayerman

15. Birthplace Balt Md

16 (a) Informant Dept Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Pulaski Highway & Hamilton Ave

18 (a) Funeral director Paul E. Lewis Inc

(b) Address 1439 E. Baltimore St

19 (a) Date received by registrar Huntington Williams, M.D.

APR 7 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 19 46 to April 5 19 46 and that I last saw [illegible] alive on April 5 19 46

Immediate cause of death	Duration
Respiratory Failure	
Due to prematurity	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. D. Treptow M. D.
Address W B&H Date signed 4-6-46

C39086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

C39086 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 0 a
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Whittier Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Moses H. Lazarus

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-4257

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1885

8. AGE: Years	Months	Days	If less than one day
60	5	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Bond Salesman

FATHER
12. Name Harry Lazarus,
13. Birthplace Lith.

MOTHER
14. Maiden Name Ida Goldstein,
15. Birthplace Lith.

16 (a) Informant Mrs. M. H. Lazarus,
(b) Address 2007 Whittier Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Chas. Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) 1946 (b) Registered by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 19 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw Dead on Arrival 19

Immediate cause of death	Duration
Hypertensive Arteriosclerotic Heart	5 yrs.
Due to Uremia	
Due to Old Myocardial infarction	
Due to Pulmonary Edema	
Other Conditions Chronic congestive failure	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad Katz M. D.
Address Sinai Hosp Date signed 4-6

Balto - X

VS 150

over

639087 BALTIMORE CITY HEALTH DEPARTMENT 639087

CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Md.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of what country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Chaney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: White
5. Color or race: Female
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Abbey 4/5/46

8. AGE: Years — | Months — | Days 1 | If less than one day — hr. — min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Prentice E. Chaney
13. Birthplace Baltimore City, Md.

MOTHER
14. Maiden Name Dorothy Osborne
15. Birthplace Baltimore County Md.

16 (a) Informant Prentice E. Chaney
(b) Address Balto City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Pleasant Grove
Location Boring, Md.

18 (a) Funeral director Wm. Berryman & Son
(b) Address Reisters Town, Md

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/46 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4, 5 1946, to 4, 6 1946, and that I last saw her alive on 4, 6 1946.

Immediate cause of death Atelectasis x possible brain damage. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. DeHaven M.D.
Address Maryland Gen. Hosp. Date signed 4/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35038 G35038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun and Fayette Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town insert NAME OF COUNTY, if RURAL and give town)
(d) Street No. 2311 Wash Blvd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME 29 Rue Patricia Driver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-3-1946

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Franklin Square Hospital (Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Browning Driver
13. Birthplace [illegible] Md
14. Maiden Name 29 Rue Curtain
15. Birthplace Balto. Md.

16 (a) Informant Father
(b) Address 2311 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Madonna Rudge
Location Wash Blvd

18 (a) Funeral director Edward Fowler
(b) Address 2359 Wash Blvd

19 (a) [illegible] (b) [illegible] (Signature of registrar)
4-7-1946 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1946, to 4-6 1946, and that I last saw h[illegible] alive on 4-6 1946.

Immediate cause of death	Duration
Congenital heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Congenital heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon O. Kaufman, M.D.
Address Franklin Square Hosp. Date signed 4/7/46

AB-100 639089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

639089 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cooperation is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME: Mary Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1- 1915

8. AGE: Years 31 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred (B)
13. Birthplace ?

MOTHER
14. Maiden Name Florence
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burtons
Location Melfa, Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) 4-7 1946 (b) Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6- 1946, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1946 to 4-6- 1946 and that I last saw h er alive on 4-6- 1946.

Immediate cause of death Cardiac Arrest

Due to Hypertensive Cardio - Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M.D.
M. D.
Address Balt. City Hosp. Date signed 4-6-46

X

G39090

HB # 100150

BALTIMORE CITY HEALTH DEPARTMENT ✓ G39090

CERTIFICATE OF DEATH 132

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Richards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife Granville

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1915

8. AGE: Years	Months	Days	If less than one day
30	7 8	24/5	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward C. Walker
13. Birthplace N.C.

MOTHER
14. Maiden Name Maria Charles
15. Birthplace S. C.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Buried (b) Date thereof 4-8-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem
Location

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Brantly ave

19 (a) (Signature of city registrar) (b) Huntington Williams M.D. Registrar

APR 7 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1946, at 4:35PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1946, to April 4 1946, and that I last saw h er alive on April 4, 19 46.

Immediate cause of death: Respiratory Failure — Duration

Due to: Tuberculous Pneumonia

Due to: Pulmonary Tuberculosis

Other Conditions: Pleural Effusion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy: Pulm. TB + TB pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Yearbrough M. D.
Address 494 Eastern Ave. Date signed 4-6-46

(over)

G39091 BALTIMORE CITY HEALTH DEPARTMENT G39091

CERTIFICATE OF DEATH 937

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and the county)
(d) Street No. 3201 Gwynns Falls Pkwy
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Emmet Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Edna Dietz
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1896

8. AGE: Years	Months	Days	If less than one day
50	1	13	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Postal Clerk
11. Industry or business

FATHER
12. Name Francis P. Cunningham
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Annie M. Dunn
15. Birthplace Maryland

16 (a) Informant Mrs. Edna D. Cunningham
(b) Address 3201 Gwynn Falls Parkway

17 (a) Burial (b) Date thereof 4/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Howard County, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

APR 7 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 April 1946, at 7 10 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardio-Vascular disease

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelsch M.D. (Medical Examiner)
Date signed 6 June 46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C38026 Registered No. 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fiduwood & Druid Hill Ave.
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 N. Charles
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Josephine Conlon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Archibald J. Conlon
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Coogan
15. Birthplace Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meades and Son
(b) Address 804 N. Calvert St.

19 (a) (Date received by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1946 to 4/5 1946 and that I last saw her alive on 4/6 1946.

Immediate cause of death Heart failure — Duration

Due to Pernicious coronary sclerosis

Due to Operation for acute pancreatitis

Other Conditions Acute pancreatitis, chronic cholecystitis

(Include pregnancy within 3 months of death)

Date of operation 4/2/46

Major findings of operation: Fat necrosis of omentum, inflammation of pancreas

Date of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. Holmes M. D.

Address University Hosp. Date signed 4/6/46

VS 150

G35093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G35093 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 Homewood Ave Fayette to W
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3229 Kingsley St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reppe, Raymond (J. Raymond Reppe)
3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Minnie Reppe
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-28-1891
8. AGE: Years 54 | Months 3 | Days 7 | If less than one day hr. min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name John Reppe
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ida Powers
15. Birthplace Baltimore Md

16 (a) Informant Minnie F. Reppe
(b) Address 3229 Kingsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md

18 (a) Funeral director J. D. Shryock & Son
(b) Address 300 Edmondson Ave

19 (a) APR 7 1946 (Date rec'd by registrar) (b) Waiting for Williams MR (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 - 1946, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-1946, to 4-4-1946, and that I last saw HIM alive on 4-4-1946

Immediate cause of death: Cerebral Vascular Accident — Duration

Due to: Hypertensive Cardiovascular D.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3427 Chestnut Ave Date signed 4/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35094 — BALTIMORE CITY HEALTH DEPARTMENT — G35094 Registered No.

CERTIFICATE OF DEATH 73a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 S./ Hilton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Hilton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE M. TRACEY

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Tracey
6 (c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.): May 3rd. 1863

8. AGE: Years: 82 | Months: 11 | Days: 1 | If less than one day: ********** min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: John Yachel
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Maryland

16 (a) Informant: Mrs. Freddie McCoy
(b) Address: 2730 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory: New Cathederal
Location: Baltimore Maryland

18 (a) Funeral director: H. B. Wisheart & Son
(b) Address: 1300 Eutaw Place..c

19 (a) Date received by registrar: APR 7 1946 (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th. 1946 at 8:A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to April 4 1946, and that I last saw her alive on April 3 1946.

Immediate cause of death: Pernicious anemia — Duration: 4 mos
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. M. Collins M. D.
Address: Frederick Ave. & Hilton St. Date signed:

Dr. Collins X 4/5/46

G35095 BALTIMORE CITY HEALTH DEPARTMENT ✓ G35095
Registered No.

CERTIFICATE OF DEATH 13a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Ellerslie Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Ellerslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Rev. Thomas Joseph Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1873

8. AGE: Years 72 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER 12. Name James Murphy
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Donnelly
15. Birthplace Ireland

16 (a) Informant Miss Murphy
(b) Address 603 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) Date received APR 7 - 1946 (b) Registrar Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1946 approx at 9 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1940, to 4/2 1946, and that I last saw h~~e~~ alive on 4/2 1946.

Immediate cause of death Acute Cardiac Dilatation — Duration Few hours

Due to Dilated Heart - Chronic myocarditis. — Duration 6 years.

Due to — Duration

Other Conditions Hypertension Chronic Interstitial Nephritis. — Duration approx 20 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Roberts M. D.
Address 1126 St Paul St Date signed 4/6/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G39096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 Jackson st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 Jackson st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Lindemann

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: August J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2-1873

8. AGE: Years 72 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Bode
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant August J. Lindemann
(b) Address 1521 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1416 Light St.

19 (a) [illegible] Arlington Williams, M.D. Registrar
(Date received by registrar) 4-8-1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1946, at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1945, to 4-4 1946, and that I last saw h-r alive on 4-4 1946

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Sollod

Address 707 Fontaine Date signed 4-5-46 M. D.

X

G39097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Josephine L. Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Joseph C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 1866

8. AGE: Years 79 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Thomas Tucker
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Pickett
15. Birthplace Md.

16 (a) Informant Mrs. Leonard Chinn
(b) Address 510 E. 41st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) (b) Huntington Williams, M.D. Registrar

Received by registrar APR 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 6 1946 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1945 to 4/6 1946 and that I last saw h. alive on 4/4 1946

Immediate cause of death Arteriosclerotic Heart — Duration 2 yrs

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Woodall

Address 2020 N. Charles Date signed 4/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. G39098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Paul & 23rd St
(c) Hospital or institution: Dr Becks. Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City 4
(If outside city or town limits write RURAL and give town)
(d) Street No. 2314 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Sheffloe

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Florence B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 11. 1863

8. AGE: Years	Months	Days	If less than one day
82	11	25	hr. min.

9. Birthplace Decorah, Iowa
(Town, county, and state)

10. Usual Occupation Educational
11. Industry or business Salesman

FATHER
12. Name Bard Sheffloe
13. Birthplace Norway

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mary A. Robertson
(b) Address 730 St Johns Rd

17 (a) Burial (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Wm Cole Inc
(b) Address 1211 St Paul St.

19 (a) APR 8 - 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930, to April 6 1946, and that I last saw him alive on April 6 1946

Immediate cause of death	Duration
Coronary Thrombosis	Twks.
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M Beck M.D.
Address 2727 N Charles St Date signed Apr 6-46

VS 150

X

G33099

BALTIMORE CITY HEALTH DEPARTMENT

491033

CERTIFICATE OF DEATH

30B

Registered No. G33099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Gastonia. (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Porter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rufus R Boyhin Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 2-22-11

8. AGE: Years 35 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER
12. Name Rufus R. Boyhin
13. Birthplace N. C.

MOTHER
14. Maiden Name Hattie E. Perkins
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-8-46 (month) (day) (year)
(c) Cemetery or crematory Greenwood
Location Lanham Md

18 (a) Funeral director Carlisle Funeral Home
(b) Address Lanham, Md

19 (a) Received [illegible] Apr 8 1946 (b) Huntington Williams, Jr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 7 1946, and that I last saw him alive on April 7 1946

Immediate cause of death: Malarial Fever Therapy — Duration 4 Hrs

Due to

Due to

Other Conditions Pneumo — Duration 2-3 Wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice B Wintrobe M. D.

Address J H H Date signed 7 Apr 46

X

G39100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G39100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5301 Catalpha Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Catalpha Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE AGNES BERGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Hendon C. Berger
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1900

8. AGE: Years	Months	Days	If less than one day
46	2	17	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Clarke
13. Birthplace England

MOTHER
14. Maiden Name Mary A. Leek
15. Birthplace England

16 (a) Informant Hendon C. Berger
(b) Address 2131 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 8 - 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH April 8 1946, at 4.05 M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 13 1946 to April 6 1946 and that I last saw h[illegible] alive on April 5 1946.

Immediate cause of death	Duration
Acute Pulmonary Edema	1 day
Due to Cirrhosis of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward C. Wolle
Address 331 E. North Ave. Date signed 4-6 46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3505 Brook Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Brook Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE LEUTBECHER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 23, 187?
8. AGE: Years 69 | Months 0 | Days 13 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name John Leutbecher
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Shaffer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lillian Dorsey
(b) Address 3505 Brook Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-46 (month) (day) (year)
(c) Cemetery or crematory St/ Paul's Fifth Ref. Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 8 - 1946 (Date rec'd by registrar) Starting for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946 at 6/30 A. M. / P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1945 to Apr. 4th. 1946. and that I last saw her alive on Apr. 4th. 1946.

Immediate cause of death: Myocardial Insufficiency — Duration: about 8mos
Due to
Due to
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Harrington M.D.
Address 401 E. 25th. St. Date signed 4/8/46.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83Q

Registered No. 639102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Whitelock St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Guy Markland Kelly.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single; infant

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1946

8. AGE: Years	Months	Days	If less than one day
0	3	01	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Caleb Guy Kelly, Jr.
13. Birthplace North Africa (Tunis)

MOTHER
14. Maiden Name Suzanne Thevenet
15. Birthplace Long Island, N.Y.

16 (a) Informant Edwin O. Hendrickson 3rd M.D.
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 8 - 1946 (Date rec'd by Local Reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1946, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1946, to April 6 1946, and that I last saw him alive on April 6 1946.

Immediate cause of death Respiratory failure due to sub-dural hemorrhage.

Due to Sub-dural hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration
4 min respiratory failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold D. Cooper M.D.

Address Union Memorial Hospital Date signed April 1946

VS 150

639103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

639103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ridgemede Rd. & Linkwood Ave.
(c) Hospital or institution: Ridgemede Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgemede Apts., Ridgemede & Linkwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWIN H. C. BROWNE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rose Silverman Browne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1892

8. AGE: Years	Months	Days	If less than one day
53	10	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Architect
11. Industry or business Self

FATHER
12. Name John B. Browne
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Walter C. Browne
(b) Address 206 E. 54th St.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 8 1946 Date rec'd by State Registrar — Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1945 to 4/5 1946.
and that I last saw h[illegible] alive on 4/5 1946.

Immediate cause of death
Acute Coronary Thrombosis
Due to Acute Coronary Sclerosis
Due to Hypocentility

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Bornstein
Address 733 Aisquith St. Date signed 4/6/46 M. D.

X

G39104 G39104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2133 N. FULTON AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 N. FULTON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY M. URBAN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: FRANK URBAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 3 1880

8. AGE: Years 66 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: JAMES FOLKER
13. Birthplace: BALTO. MD.

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: BALTO. MD.

16 (a) Informant: FRANCIS URBAN (SON)
(b) Address: 6216 HAMILTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 10/46 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BELAIR ROAD

18 (a) Funeral director: Eddy & Geiler Inc.
(b) Address: 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) APR 8 - 1946 (b)

VS 10

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH APR. 7 1946 at 2/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to April 7 1946 and that I last saw h.e.r alive on April 7 1946.

Immediate cause of death: Acute Cardio-Respiratory Decompensation — Duration: 2 months
Due to: Chronic Hypertension & Myocarditis — Duration: ?
Due to: Chronic Nephritis — Duration: ?
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Louis Steinbo
Address: 200 E. Pratt St. Date signed 4/8/46

X

39105 G39105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

Registered No. G 43880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital, V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days V
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E Lee St. Baltimore 2 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Hershman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife Dora Hershman

6 (c) If alive, give age 17 years

7. Birth date of deceased (mo., day, yr.) 3/8/1946

8. AGE: Years	Months	Days	If less than one day
		16 24 hr.	min.

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School APR 5 1946
Location Commissioner of Health

18 (a) Funeral director

(b) Address

19 APR 8 1946 (Date rec'd by Registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1946, to April 1 1946 and that I last saw h. 13. alive on April 1 1946

Immediate cause of death	Duration
Perforation of gastric ulcer	
Due to Dehydration	
Due to Anorexia	
Other Conditions Malnutrition Birth 2 wks. before death (Include pregnancy within 3 months of death)	

Date of operation none

Major findings of operation none

of autopsy: Dehydration, Emaciation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Robert E. McCurdy M. D.

Address University Hosp. Date signed 4/2/46

VS 150

3403 X

639106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HB # 100108

Registered No. 639106 830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Reimen Ross Williar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years	Months	Days	If less than one day
60 Y ?			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Williar
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie McCulloh
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 5 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 8 1946 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1946, at 1:PM M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1946, to March 30 1946, and that I last saw h 1m alive on March 30, 1946

Immediate cause of death: Respiratory Failure — Duration: 12 hrs.
Due to Cerebro-Vascular Accident — 2 days
Due to Cerebral Arteriosclerosis — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. K. Hargrove M.D.
Address 4940 Eastern Ave. Date signed 4-5-46

VS 150

3402

X

Stillbirth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

Registered No. 58107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Ivanhoe Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Kearns

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Bandoom
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-46

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace: md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ?

MOTHER
14. Maiden Name Naomi Kearns
15. Birthplace ?

16 (a) Informant: Friends
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School APR 5 1946

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) APR 8 1946 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 28 1946, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1946 to March 28 1946 and that I last saw h.m. alive on March 1946

Immediate cause of death: Intestinal Obstruction — Duration

Due to: ? Atresia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Clifton D. Gaston M. D.
Address: NH
Date signed 3-28-46

3401

639108
491278

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193D

639108
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL q

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Eisenberg

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [redacted] 1875

8. AGE: Years 70 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace: Lithuania
(Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business

FATHER
12. Name: Jacob
13. Birthplace: Lith

MOTHER
14. Maiden Name: Gittel
15. Birthplace: Lith

16 (a) Informant: Friend.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-46 (month) (day) (year)
(c) Cemetery or crematory: Windsor Mill Rd
Location

18 (a) Funeral director: Jack Levine Inc
(b) Address: 1399 E. Balto St

19 (a) APR 8 - 1946 (Date received by Registrar) (b) [illegible] Washington Wilkerson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1946 to April 6 1946 and that I last saw him alive on April 6 1946

	Duration
Immediate cause of death: Subarachnoid hemorrhage	3 days
Due to: Hypertensive vascular disease	
Due to: generalized arteriosclerosis	? 2 yrs
Other Conditions: Bilat. inguinal hernia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Eugene Meyer M.D.
Address: Johns Hopkins Hosp Date signed April 6

VS 150

639109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700C

639109 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Rd & 10th Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel K Watts

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	214-24-1682

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Calvin G Watts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1928

8. AGE: Years	Months	Days	If less than one day
17	10		hr. min.

9. Birthplace Baltimore County Md
(Town, county, and state)
10. Usual Occupation Bench Hand
11. Industry or business

FATHER
12. Name Wilfred D Fuller
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Frieda Eichler
15. Birthplace Unknown

16 (a) Informant Edward Watts
(b) Address Fullerton, Md

17 (a) Burial (b) Date thereof 4/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) APR 8 1946 (b) Huntington Williams Registrar
Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/46 2:00 AM 19 at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Multiple fractures, laceration & brain lesions.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27-8
(a) Date of injury 4-7- at 1.45 a. M.
(b) Where did injury occur? York Rd. Northern Pkwy
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Collision of automobile & passenger

23. Signature Howard J. Tamdeis M.D.
Medical Examiner.
Date signed 4-7-46

VS 151

639110 — BALTIMORE CITY HEALTH DEPARTMENT — 639110

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 McKean Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McCullough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/46

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony McCullough
13. Birthplace

MOTHER
14. Maiden Name Evelyn McCullough
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 8 1946 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location 7225 Eastern Ave

18 (a) Funeral director Harry K Witzke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

APR 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1946 to 4/7 1946 and that I last saw him alive on 4/7 1946

Immediate cause of death
Prematurity
Due to Spontaneous abortion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stuart D Ruzika M.D.
Address St. Agnes Hosp Date signed 4/7/46

Funeral Director for Williams

G39111

G39111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 Keystone Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Chestnut Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Killanna Leaf

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Benjamin N. Leaf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9-1887

8. AGE: Years 58 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William N. Keller
13. Birthplace Maryland

MOTHER
14. Maiden Name Alpha Lovell
15. Birthplace Maryland

16 (a) Informant Benjamin N. Leaf
(b) Address 3313 Chestnut Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8-1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Date rec'd by local reg. APR 8 1946 (b) Signature of local registrar Huntington Willis, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946, at 9:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1945 to Apr. 5 1946 and that I last saw h[illegible] alive on Apr. 5 1946

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Carcinoma of Lung (metastatic)

Due to: Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward P. Hassman M.D.

Address 4031 Falls Rd. Date signed 4/9/46

X

G39112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95D

G39112
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4609 Ochenley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4609 Ochenley Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME L. Merryman Hare

3 (b) If veteran, name war —
3 (c) Social Security Account No. 17-03-9388A

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Virginia Hager Hare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1875

8. AGE: Years 70 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Samuel P. Hare
13. Birthplace Maryland

MOTHER 14. Maiden Name Martha Miller
15. Birthplace Maryland

16 (a) Informant Mrs. Virginia H. Hare
(b) Address 4609 Ochenley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10-1946 (month) (day) (year)
(c) Cemetery or Crematory Greenmount
Location Carroll Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Huntington Witt Registrar

APR 8 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8- 1946, at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apl. 1 1946 to Apl. 7, 1946, and that I last saw h[illegible] alive on Apr. 7 1946.

Immediate cause of death: Acute Pulmonary Edema — Duration 2 days
Due to: Hypertension Heart Disease — 2 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Gilson Porter, M.D.
Address 4822 Roland Ave Date signed 4/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √93D

G39113

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6003 Deffon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 6003 Deffon Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Dietrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lotta Dietrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1866

8. AGE: Years 79 | Months 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Brewer

11. Industry or business Retired

FATHER 12. Name Dont Know

13. Birthplace Baltimore

MOTHER 14. Maiden Name Dont Know

15. Birthplace Baltimore

16 (a) Informant Edgar C Dietrich

(b) Address 600 B Defton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) APR 8 1946 (Date of dy registrar) (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946 at 6·9 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1946, to April 5 1946, and that I last saw h.i.m alive on April 4 1946

Immediate cause of death Coronary Occlusion — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Henry Hamm M. D.

Address 5106 Hayfield Rd. Date signed April 6 1946

VS 150

G39114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G39114

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 118 S. Haven St.,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 118 S. Haven St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH MOERSCHEL

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Moerschel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1879

8. AGE: Years	Months	Days	If less than one day
67	1	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Schmidt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marha Witheroe
15. Birthplace West Virginia

16 (a) Informant Mrs. Laura Morgan,
(b) Address 118 S. Haven St.

17 (a) Burial (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Filed by) (b) [illegible] Huntington W. Va.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1946 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1945 to April 4 1946 and that I last saw her alive on 4-4 1946.

Immediate cause of death myocardosis

Due to arteriosclerotic heart disease

Due to arteriosclerosis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J J Gould M. D.

Address 1744 Eastern Ave. Date signed 4-5-46

VS 150

G39115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

G39115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere ave & Greenspring ave.
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 N Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Wolf.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 83 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business H. Wife.

FATHER
12. Name Jonas Goodman
13. Birthplace Poland.

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Poland

16 (a) Informant Meyer Wolf
(b) Address 1722 n Pulaski st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cemetery
Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 1.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1946 to 4-7 1946 and that I last saw h alive on 4-7 1946

Immediate cause of death	Duration
Left cerebral hemiplegia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hedwig L Levin

Address Levindale Date signed 4/7/46

G39116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G39116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Greenmount Ave
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Meyer

3 (b) If veteran, name war No

3 (c) Social Security Account No. 216-01-4438

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edna Mar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1876

8. AGE: Years 70 | Months | Days 28 | If less than one day hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name George Meyer
13. Birthplace Germany

MOTHER
14. Maiden Name Adline ?
15. Birthplace Germany

16 (a) Informant Era Rodrick
(b) Address 1704 E 31 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 9 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Smith & E. Bogard's
(b) Address 37 S. Ann St.

19 APR 8 - 1946 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1946 to 4/6 1946 and that I last saw h[illegible] alive on 4/6 1945.

Immediate cause of death	Duration
Coronary Thrombosis -	
Due to Arteriosclerosis	(?)
Due to Paroxysmal Tachycardia	(?)
Other Conditions	

(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel E. Bogard
Address 1905a W. Balto. Date signed 4/6/46.

VS 150

X

G39117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

G39117

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1051 Aisquith St
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1051 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Agnes Turner

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Jan. 17th 1906

8. AGE: Years	Months	Days	If less than one day
40	2	19	hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Travies Turner
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Robinson
15. Birthplace Va.

16 (a) Informant Agnes Turner
(b) Address 1051 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. G. Co. Md.

18 (a) Funeral director Byron M. Smith & Haight
(b) Address 721 Aisquith St

19 (Date received by registrar) APR 8 1946 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 April 1946, at 4. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 March 1946 to 5 April 1946, and that I last saw him alive on 3 April 1946

Immediate cause of death	Duration
acute respiratory & circulatory failure.	
Due to Anemia & cachexia.	
Due to unknown causes.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell M. D.
Address 121 Aisquith Date signed 4-8-46

G39118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G39118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 Augusta St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burley Clement

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-1915

8. AGE: Years 31 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Burley Clement
13. Birthplace N.C.

MOTHER
14. Maiden Name Rebecca Ammie
15. Birthplace N.C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-46 (month) (day) (year)

(c) Cemetery or crematory
Location Durham, N.C.

18 (a) Funeral director Elroy O. Wilson
(b) 1000 Berkeley Ave

19 (a) APR 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 1:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 4-6 1946, and that I last saw h[illegible] alive on 4-6 1946

Immediate cause of death: Infarction of anterior myocardium — Duration

Due to: Myocarditis of unknown cause

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Austen
Address Johns Hopkins Hosp. Date signed 8 Apr 46 (M. D.)

X

Please write plainly in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39119

491022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G39119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 E Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora Mae

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-05

8. AGE: Years	Months	Days	If less than one day
40	7	23	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jas. McAlister
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Jones
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Oldfield
(b) Address 1000 Bradley ave
4/8-1946 (Date rec'd by Registrar) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 7 1946 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 7 1946 and that I last saw her alive on April 7 1946

Immediate cause of death Resp. Coma — Duration

Due to Acute brain embolism

Due to Mitral stenosis and R.H.D.

Other Conditions A-fib. tachycardia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Dukash M. D.
Address J H H Date signed 4/7/46

VS 150

THESE WHITE SPACES, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Kasprzak.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-85

8. AGE: Years 60 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Poland. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael Kasprzak

13. Birthplace Poland.

MOTHER 14. Maiden Name Frances Z.

15. Birthplace Poland

16 (a) Informant Relative

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School APR 8 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 APR 8 1946 Huntington Williams M.D. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March-23 1946 at 6.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch-22-1946 to March-23 1946 and that I last saw him alive on March-23 1946

	Duration
Immediate cause of death Pulmonary Edema	1 wk.
Due to Hypertensive cardiovascular disease	??
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Pendergrass

Address Johns Hopkins Hosp. Date signed 4-5-46

VS 150

F 3404 X

PRESS WHITE PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 639121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 W. Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town (milk) write RURAL and give town)
(d) Street No. 1111 W Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara V. Richardson Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8th 1946 (month) (day) (year)

(c) Cemetery or ~~crematory~~ St Matthews

Location O'Donnell St Ext

18 (a) Funeral director Leo G. Leach

(b) Address 1701-03 N Patterson Park Ave

APR 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1946 at 6 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. J. Helbrick M.D. Medical Examiner.

Date signed April 8 46

...the causes of death clearly and legibly. Physicians: please write...

G39122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. G39122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Melissa E. Watson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mildred Watson
(b) Address 410 E 21st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/46 (month) (day) (year)
(c) Cemetery or crematory Pine Grove Cem. Co
Location Mt. Airy, Md.

18 (a) Funeral director Fraught Funeral Home Inc.
(b) Address 20 Fremont Ave

19 (a) APR 8 - 1946 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946, at 5:19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1946 to 4/7 1946 and that I last saw her alive on 4/7 1946.

Immediate cause of death	Duration
Shock Due To Fracture of Left Femur	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4/6/46 at M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public Alley While at work? No
(Specify type of place)
(e) Means of injury Fell

23. Signature Luther H. Young M. D.
Address St. Joseph's Hospital Date signed 4/7/46

For S. J. R. Davis by Howard T. Wheeler, M.D.

VS 150

Please write plainly, with pen and ink. Copy items of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 639123

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Light ST.
(c) Hospital or institution: South Baltimore Journal
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DA
(e) Length of stay in Baltimore (yrs., mos., or days) DA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Williams Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE KAIROS

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	divorced

6 (b) Name of husband or wife Violet D Stanley
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) JAN. 10 1899

8. AGE: Years	Months	Days	If less than one day
47	2	27	hr. min.

9. Birthplace GREECE (Town, county, and state)
10. Usual Occupation PROPRIETOR
11. Industry or business CONFECTIONARY STORE

FATHER
12. Name JIM DIMITRI
13. Birthplace GREECE

MOTHER
14. Maiden Name STELLA STAMATA
15. Birthplace GREECE

16 (a) Informant HELEN MARIS
(b) Address 1010 WILLIAM ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-46 (month) (day) (year)
(c) Cemetery or crematory GREEK CEMETERY
Location WINDSOR MILL Road

18 (a) Funeral director KRAUSE FUNERAL HOME
(b) Address 216 S. CHARLES ST.

19 APR 8 1946 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/46 19 , at 12:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Williams, M.D.
Medical Examiner.
Date signed 4/6/46

639124 Perret-Gentil 639124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Curacao (If outside city or town limits, write RURAL and give town)
(d) ~~Street No.~~ Netherland (If rural give location)
(e) Citizen of foreign country? W.I. (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar E. Perret-Gentil

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-84

8. AGE: Years 61 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Venezuela (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Casper Perret Gentil
13. Birthplace W.I.

MOTHER 14. Maiden Name Elodie Auendaut
15. Birthplace P.R.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9/46 (month) (day) (year)
(c) Cemetery or crematory Curacao D.W.I.
Location British West Indies

18 (a) Funeral director Peter Cunningham
(b) Address 1906 Eutaw Place

19 MAY 8 1946 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1946 to April 5 1946 and that I last saw him alive on April 5 1946.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Lymphosarcoma	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Gaud III
Address Johns Hopkins Hosp. Date signed 4/5/46

VS 150

FORMER WRITE FIRMLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39125 G39125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward Ave & Falls Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Thomas W. Henry Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1905

8. AGE: Years	Months	Days	If less than one day
40	6 7	21	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas W. Henry Sr.
13. Birthplace Hagerstown, Pa.

MOTHER
14. Maiden Name Laura Reams.
15. Birthplace Md.

16 (a) Informant Laura Henry
(b) Address 420 Chestnut St. Towson's Md.

17 (a) Burial (b) Date thereof 4-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Penna Ave. #1 (b) Huntington Williams, M.D.
(Date rec'd by Local Registrar) Registrar

APR 8 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-1946 at 9:20 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Hypertrophic Cirrhosis

Due to .....

Other Conditions Edema & Congestion of brain
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Sheridan M.D.
Medical Examiner.
Date signed 4-5-46

The cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G39126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave.
(c) Hospital or institution: Maryland G. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Garrison
(If outside city or town limits, write RURAL and give town)
(d) Street No. Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebel Ashler Pearce

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-12-0928

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3rd 1903

8. AGE: Years	Months	Days	If less than one day
43	3	4	hr. min.

9. Birthplace Baltimore Co. Md
(Town, county, and state)

10. Usual Occupation Personal Manager

11. Industry or business

FATHER
12. Name George C. Pearce
13. Birthplace Baltimore Co. Md

MOTHER
14. Maiden Name Blanche Clemworth
15. Birthplace Balto. Co. Md.

16 (a) Informant Rose Knott Pearce
(b) Address Garrison. Md.

17 (a) Burial (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville. Md.

18 (a) Funeral director Frank H. Spurrell
(b) Address Pikesville. Maryland

19 (a) (b)
Received by registrar APR 8 - 1946 Huntington, W. Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1946, at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6th 1946 to April 7th 1946, and that I last saw him alive on April 1st 1946.

Immediate cause of death	Recurrent Coronary Thrombosis		
Due to	Coronary sclerosis		
Due to			
Other Conditions			

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzales M.D.
Address Maryland G. Hospital Date signed 4/9/46

639127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

639127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Richard B. Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1st 1869.

8. AGE: Years 76 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Calvert Co. Md.
(Town, county and state)

10. Usual Occupation House Wife.

11. Industry or business Domestic.

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name not Known
15. Birthplace Not Known

16 (a) Informant Richard B. Carter
(b) Address 939 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) APR 8 - 1946 (Filed by registrar) Huntington Williams

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6th 1946 to April 3, 1946 and that I last saw her alive on 4/3, 1946.

Immediate cause of death	Duration
Acute Myocarditis	2 weeks
Due to Interstitial Nephritis	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature J. T. Gleason M. D.
Address 322 N. Arlington Ave Date signed 4/5/46

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G39128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G39128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wanda Bennett Bernatowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-190[illegible]

8. AGE: Years 45 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Md (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Cornelius Kicka

13. Birthplace Md

MOTHER 14. Maiden Name Caroline ?

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W Ohrenschall

(b) Address 1930 Eastern Ave

19 (c) APR 8 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 6 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1946, April 6 1946 and that I last saw h[illegible] alive on April 6 1946.

Immediate cause of death: Carcinoma of the Liver — Duration 4 years

Due to

Due to

Other Conditions [redacted]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Austin M.D.

Address Johns Hopkin Hosp. Date signed 6 Apr 46

VS 150

X

G39129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G39129 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 S Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 S Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Rostkowski

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1892

8. AGE: Years	Months	Days	If less than one day
54	1	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Wozniak
13. Birthplace Poland

MOTHER
14. Maiden Name Jos Kowalski
15. Birthplace Poland.

16 (a) Informant Edward Rostkowski
(b) Address 641 S Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarzenski
(b) Address 1930 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Funeral Home Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946, to April 4 1946 and that I last saw h[illegible] alive on April 4 1946.

Immediate cause of death	Duration
Coronary Thrombosis with Metastasis	6 mos.
Due to	
Due to	
Other Conditions Uterine Effusion	1 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address 2007 E Pratt Date signed 4/8/46

VS 150 APR 8 - 1946

G39130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G39130

PLEASE WRITE PLAINLY, with permanent ink, and write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Bank Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Bank Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maryanna Krawczyk

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Anthony Krawczyk
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1893

8. AGE: Years	Months	Days	If less than one day
53	1	22	....hr. ....min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ludwig Sawecki
13. Birthplace Poland

MOTHER
14. Maiden Name Pauline Diantea
15. Birthplace Poland

16 (a) Informant Anthony Krawczyk
(b) Address 2215 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Rosary
Location Balto. Cardenty Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann st

19 (a) Filed by (b) Huntington Williamsport, Md.

APR 8 1946

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1945 to April 7th 1946, and that I last saw her alive on April 6th 1946

Immediate cause of death Uraemia — Duration 14 days

Due to Chr. nephritis — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1126 Paffon Grove St. Date signed 4/7/46

X

G39131 Dr. Evan A. Gilkes G39131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 N. Spring St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 N. Spring St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Wilkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Walter Wilkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1898

8. AGE: Years 47 | Months 48 | Days 6 7 | If less than one day 21 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation ~~Housewife~~ Wife

11. Industry or business

FATHER
12. Name William Foster
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Spencer
15. Birthplace Maryland

16 (a) Informant Walter Wilkins
(b) Address 1302 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston Street

19 (a) APR 8 1946 Huntington Williams
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 6 1946, at 5 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/17 1946 to 4/6 1946 and that I last saw h[illegible] alive on 4/6 1946

Immediate cause of death: Hypertensive Type Heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan A. Gilkes
Address 601 N. Calhoun St Date signed 4/6/46 M

VS 150

X Gilkes

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G39132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs. 11 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3929 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cowlyn Ann Tennette

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1943

8. AGE: Years	Months	Days	If less than one day
2	11	30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Wilbur Tennette
13. Birthplace Virginia

MOTHER
14. Maiden Name Jessie May Phillips
15. Birthplace Baltimore Md.

16 (a) Informant Jessie May Phillips
(b) Address 3929 Roland Ave, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampdale

18 (a) Funeral director Skinner & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date signed by Registrar) (b) Registrar

APR 8 - 1946
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1946 to April 5 1946 and that I last saw her alive on April 5 1946.

	Duration
Immediate cause of death Respiratory failure	
Gangrenous appendicitis	immediate
Due to	
Gangrenous appendicitis	36 hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 5, 1946
Major findings of operation: Gangrenous Appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Williams & Penner M. D.
Address Union Memorial Hospital Date signed 6/

Wm Kimball Jr M.D. X

Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

639133 639133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Burke Ave Towson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley R. Cape

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 1-1926

8. AGE: Years	Months	Days	If less than one day
20	3	6	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Farm

FATHER
12. Name John Cape
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah S. Sterner
15. Birthplace Maryland

16 (a) Informant John Cape
(b) Address 226 Burke Ave - Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-46 (month) (day) (year)

(c) Cemetery or crematory Manchester
Location Manchester Md.

18 (a) Funeral director Jacob Wink's Son
(b) Address Manchester Md.

19 APR 8 - 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7- 1946, at 2.26 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cranial Abscess.

Due to

Other Conditions Multiple fractures, laceration & brain bruise.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 27-12

(a) Date of injury 4-7-46 at 2 A. M.
(b) Where did injury occur? Cor. York Rd. & Lake ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 4-8-46

VS 151

G30134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G39134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA MAY VANCE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Charles M. Vance, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1875

8. AGE: Years	Months	Days	If less than one day
70	11	9	hr. min.

9. Birthplace Palestine, Ind.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Henry Morton
13. Birthplace Mass.

MOTHER
14. Maiden Name Mary V. Meridith
15. Birthplace Lexington, Ky.

16 (a) Informant Mr. Charles M. Vance, Jr.
(b) Address 4112 Belvieu Ave.

17 (a) Burial (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 8 1946 (Date received by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1946, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Feb 1946 to 5 April 1946, and that I last saw h er alive on 4 April 1946.

Immediate cause of death Congestive Heart Failure — Duration 3 weeks
Due to arteriosclerotic Heart Dis
Due to
Other Conditions Chronic Mucous colitis; Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Nathan Rosen M. D.
Address 206 S. Gilmor St Date signed 4-8-46

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G39135 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Bruce St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Elizabeth Fogle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hamilton F. Fogle

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 15, 1873

8. AGE: Years 62 | Months 10 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business Marlboro Shirt Co.

FATHER
12. Name Howard Hatfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Marsh
15. Birthplace Maryland

16 (a) Informant Mrs Agnes Saffran
(b) Address 2513 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1946 (month) (day) (year)
(c) Cemetery or crematory New National
Location Baltimore

18 (a) Funeral director Frederick A Cole
(b) Address 1200 N Lombard St

19 (a) 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1946, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1945 to April 6 1946, and that I last saw h[illegible] alive on April 6 1946.

Immediate cause of death — Coronary Thrombosis — Duration 1 hr.
Due to Diabetes — 5 yrs.
Due to Arteriosclerosis — 5 yrs.
Other Conditions — 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. W. Coons M. D.
Address 1202 St Paul St Date signed 4/8/46

VS 150

1

G39136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39136

please write the causes of death clearly and legibly. Physicians: please

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway & Fairmount

(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3700 Mahmudo Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME JACKSON, CORDELIA MAY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/30/1862

8. AGE: Years 83 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housekeeping

11. Industry or business —

FATHER

12. Name William Jackson

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Caroline Hitchcock

15. Birthplace Harford County, Md.

16 (a) Informant Deceased

(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 9-46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Woodlawn

18 (a) Funeral director Sherwood Memorial

(b) Address 1082 Cathedral St.

18 (c) 1946 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/46, 1946, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/1946 to 4/7/1946 and that I last saw h. R.R. alive on 4/6/1946.

Immediate cause of death: Coronary Occlusion — Duration: ?

Due to: Arteriosclerotic Heart Disease — Duration: Years?

Due to: —

Other Conditions: Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. D. Patten, M.D.

Address Church Home Hospital Date signed M. 4 D. 7/46

VS 150

639137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

639137
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mon.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 E. Centre st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Patrick Gay

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 1, 1882

8. AGE: Years	Months	Days	If less than one day
63	11	7	hr. min.

9. Birthplace Franklin, Va.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Josiah Powell Gay
13. Birthplace South Hampton Co., Va.

MOTHER
14. Maiden Name Emma Lee
15. Birthplace Va.

16 (a) Informant Mrs. J. F. Bryant, Jr.
(b) Address Franklin, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-46 (month) (day) (year)
(c) Cemetery or crematory Poplar Springs
Location Franklin Va.

18 (a) Funeral director Howard McClenny Co.
(b) Address 10 E. Chase and Park Ave. Huntington Williams, Md.

APR 8 - 1946 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9-1946, at 1:25 A. M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulleneaux M.D.
Medical Examiner.
Date signed 4-8-46

639138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 936

Registered No. 639138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha P. Janicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-1915

8. AGE: Years	Months	Days	If less than one day
30	3	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Paul Janicki
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Karlanty
15. Birthplace Poland

16 (a) Informant Mrs. Mary Samulanis
(b) Address 2204 E. Fairmount Ave

17 (a) Burial (b) Date thereof 4 10 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 401 S. Chester St

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 8 - 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-1946, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski, M.D.
Medical Examiner.
Date signed 4-8-46

Res. Howard J. Andrews, M.D.

1039589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

939139 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S. Rafella St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Mondo (ANDREW MONDO)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-09-4001

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine Tsakimaga

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Dec. 1. 1880

8. AGE: Years 65 | Months 4 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Finland (Town, county, and state)

10. Usual Occupation Millwrecker

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Thomas Mondo
13. Birthplace Finland

MOTHER
14. Maiden Name Anna ?
15. Birthplace Finland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10. 1946 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore Md

18 (a) Funeral director Henry Sonder & Sons. Inc
(b) Address North Ave & Broadway,

19 (a) APR 8 - 1946 (Date rec'd by registrar)

Huntington Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946 at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1946 to April 7 1946 and that I last saw him alive on April 7 1946

Immediate cause of death: Pneumonia and exhaustion — Duration
Cardiac failure
Due to
Due to Carcinoma of Stomach
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation April 27, 1945
Major findings of operation: Carcinoma of Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John William Hilgeman
Address Johns Hopkins Hospital Date signed April 8, 1946

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

639140 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3223 Elliott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Elliott St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? 60 years

3 (a) FULL NAME John Karwacki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed.

6 (b) Name of husband or wife Michalena Gorecka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 May 1873

8. AGE: Years	Months	Days	If less than one day
72	10	16	— hr. — min.

9. Birthplace Poznan, Poland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Karwacki
13. Birthplace Poland

MOTHER
14. Maiden Name — Powlok
15. Birthplace Poland

16 (a) Informant Miss Helen Karwacki
(b) Address 3223 Elliott Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 Apr. 46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Zielowski Jr.
(b) Address 1000 S. Kenwood Ave.

19 (a) (b)

APR 8 1946 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to April 7 1946 and that I last saw h. alive on April 7 1946.

Immediate cause of death	Duration
CORONARY THROMBOSIS	
Due to ARTERIO SCLEROTIC & HYPERTENSIVE CARDIO VASC DISEASE	2 YRS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen C. Mockowski
Address 6714 Holabird Ave Date signed April 7, 1946 M. D.

X

G39141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

118

Registered No. G39141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution:
MERCY HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town BALTO. 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 ENSOR ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
MR. WILLIAM B. MULLEN

3 (b) If veteran, name war
No

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MRS ANNA MULLEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1891

8. AGE: Years 55 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation ICE MAN

11. Industry or business

FATHER
12. Name PETER B. MULLEN
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name MARGARET RUSSELL
15. Birthplace BALTIMORE

16 (a) Informant Mrs Anna E. Mullen
(b) Address 1501 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Cowdin & Son
(b) Address 22-1945 Eager St.

19 (a) APR 8 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/ 1946, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 18 1946 to APRIL 7 1946 and that I last saw HIM alive on APRIL 7 1946

	Duration
Immediate cause of death RESPIRATORY FAILURE	
Due to BRONCHOPNEUMONIA	
Due to POST OPERATIVE (?)	
Other Conditions INTESTINAL OBSTRUCTION	

(Include pregnancy within 3 months of death)

Date of operation 4/4/46

Major findings of operation PYLORIC STENOSIS

of autopsy BRONCHOPNEUMONIA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul R. Pagel, M. D.
Address Mercy Hospital Date signed 4/7/46

VS 180

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

39142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111 c

Registered No. G39142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 W Hoffman 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gil Thomason

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 days 3/28/46

8. AGE: Years	Months	Days	If less than one day
		2 days	hr. min.

9. Birthplace Cato, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Donald Smoye
13. Birthplace W. Va

MOTHER 14. Maiden Name Mary Evelyn Thomason
15. Birthplace Md

16 (a) Informant Mother
(b) Address 608 W Hoffman Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 8 1946 (Date rec'd by registrar) (b) Huntington for Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30, 1946 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28-46 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Due to Cause undetermined	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy pulmonary edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Seaman M. D.
Address Sinai Hosp. Date signed

VS 3

3409 X

G39143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G39143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 95
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71 ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Homestead St., Balto. 18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Jacob Reed Gill

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Elizabeth Gill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1875

8. AGE: Years	Months	Days	If less than one day
71	1	0	4 hr. 50 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Blacksmith, retired
11. Industry or business Business

FATHER
12. Name Jacob Gill (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Naylor
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth J. Gill
(b) Address 935 Homestead st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/1946 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Roland ave. & Hoffman st.

18 (a) Funeral director Howard A. Gill
(b) Address 19 W. Penna. ave. Towson

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

APR 8 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 46, at 4:58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1946 to 4/6 1946 and that I last saw h[illegible] alive on 4/6 1946.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerosis + Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard L Dulmadge
Address Union Mem'l Hosp Date signed 4/6/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39144 — BALTIMORE CITY HEALTH DEPARTMENT — G39144

CERTIFICATE OF DEATH

Registered No. 944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 North Washington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 2023 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SCHWEITZER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theresa Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1882

8. AGE: Years 63 | Months 9 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman Sales Rep.

11. Industry or business Cedar

FATHER
12. Name Gustus Schweitzer
13. Birthplace Germany

MOTHER
14. Maiden Name Helena Geier
15. Birthplace

16 (a) Informant J. M. Schweitzer
(b) Address 4316 Reisterstown Rd

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson Corkran
(b) Address 1211 N. Paul St

(Date received) APR 9 1946 (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/46 19... at 5:45 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 4/8/46

G39145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 N. Lexington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Benninghaus Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert H. Tucker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Alice V. Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 23, 1876

8. AGE: Years	Months	Days	If less than one day
69	3	15 16	hr. min.

9. Birthplace Chestertown, Maryland
(Town, county, and state)
10. Usual Occupation Machinist Helper - retired
11. Industry or business

FATHER
12. Name James A. Tucker
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Casden
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret Clifford
(b) Address White Sulphur Springs, W. Va.

17 (a) burial (b) Date thereof 4/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Church Hill, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

APR 9 1946 (Date rec'd by Registrar) (b) Huntington Will, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/46 1946, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 7 1946 to APRIL 8 1946, and that I last saw him alive on APRIL 8 1946

	Duration
Immediate cause of death: POLMONARY EDEMA	4 days
Due to ARTERIO SCLEROTIC HEART DISEASE	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Klemm M. D.
Address 3803 Edmondson Date signed 4/8/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. G39146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St + Calvert
(c) Hospital or institution: Union Memorial Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md ✓ (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5904 Bellona Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Randall H. Laudeman Londeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Wh

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs Clara B. Laudeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2 - 1879

8. AGE: Years 67 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired - Clerk

11. Industry or business B & O R.R.

FATHER
12. Name Wm H Londeman

13. Birthplace Balto. Md

MOTHER
14. Maiden Name Martha A Hitchcock

15. Birthplace Balto. Md

16 (a) Informant Elsa G Londeman

(b) Address 5904 Bellona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore Md

18 (a) Funeral director Tilburn Cook Inc

(b) Address 1219 Cont St

APR 9 - 1946 (Date rec'd) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1946 to 4-7 1946 and that I last saw him alive on 4-7 1946

Immediate cause of death: Cardio-Respiratory failure — Duration

Due to Pulmonary edema

Due to Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul B. Tome, M. D.

Address Union Memorial Hosp. Date signed 4/7/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39147 Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G39147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County.....
(c) City or town Culpeper. (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles Strother Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11 1945

8. AGE: Years | Months: 9 | Days: 27 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name Chas. Strother
13. Birthplace N. C. —

MOTHER — 14. Maiden Name Anne Greene —
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 9 46 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Culpeper Va

18 (a) Funeral director Culpeper Funeral Parlor
(b) Address Culpeper Va

19 APR 9 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8 1946 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1946 to April 8 1946 and that I last saw h. alive on April 8 1946.

Immediate cause of death Cardiac failure — Duration

Due to Congenital Heart Dis
Tetralogy of Fallot

Due to

Other Conditions Bronchitis, acute

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George M Palmer M.D.
Address Johns Hopkins Hosp Date signed 4-8-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G39148 per

BALTIMORE CITY HEALTH DEPARTMENT

HB # 100226

CERTIFICATE OF DEATH 159

G39148 Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Cavendish Way O'Donnell Hgts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Girl Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Newborn

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1946

8. AGE: Years	Months	Days	If less than one day
6 Days		6 7	hr. min.

9. Birthplace Baltimore City Hospitals
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Mills
15. Birthplace Pa.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 4-6-46 9 a. m. (month) (day) (year)
(c) Cemetery or crematory B.C.H.
Location 4940 Eastern ave.

18 (a) Funeral director
(b) Address

APR 9 1946
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1946 at 6:05A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1946 to April 5, 1946. and that I last saw h. alive on April 5, 1946

Immediate cause of death Prematurity
Respiratory Failure

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Prematurity

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Baltimore City Hospitals Date signed April 5

VS 150

X

639149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

639149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 West Read St
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 West Read St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Bond Hamman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife Louis Hamman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 25 Feb 1892

8. AGE: Years	Months	Days	If less than one day
54	1	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Social Service
11. Industry or business

FATHER
12. Name Nicholas O. Bond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Campbell Marsh
15. Birthplace Baltimore

16 (a) Informant Louis Hamman Jr.
(b) Address US Naval Hosp. Bethesda Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 9 1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location: Balto Md

18 (a) Funeral director Henry H. Jenkins & Son
(b) Address McCulloh & Richard Sts.

APR 9 1946 (Date received by Registrar) (Signature of Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945 to Apr 7 1946.
and that I last saw h[illegible] alive on 4/6 1946.

Immediate cause of death	Duration
Cerebral Metastases	4 mos
Due to Carcinoma of breast	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. W. Wainwright M.D.
Address 9 E Chase St Date signed 4/8/1946

VS 150

PLEASE WRITE PLAINLY, WITH PENCIL OR PEN. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

✓ G39150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 Liberty Heights Ave.
(c) Hospital or institution:
Alberta Convalescing Home ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mks
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4505 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Cook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife A. Lee Cook, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1861

8. AGE: Years	Months	Days	If less than one day
84	7	15/16	hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew McCaddin
13. Birthplace Norfolk, Va.

MOTHER
14. Maiden Name Elizabeth A. Storey
15. Birthplace Elizabeth City, N. C.

16 (a) Informant Mrs. Norman Moran
(b) Address 4505 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Hamond
(b) Address 4510 Liberty Heights Ave.

19 (a) APR 9 - 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 2.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1946 to April 7 1946, and that I last saw h.er alive on April 6 1946

Immediate cause of death	Duration
Embolism	
Mitral Insufficiency	
Due to	
Due to	
Other Conditions Hypertension Congest	2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Daly M. D.
Address Medical Arts Bldg Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

639151 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 W. Lee st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1936

8. AGE: Years	Months	Days	If less than one day
9	10	1	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Jerome Nichols
13. Birthplace Va.

MOTHER
14. Maiden Name Mable George
15. Birthplace S.C.

16 (a) Informant Mable George
(b) Address 608 W. Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/46 (month) (day) (year)
(c) Cemetery or crematory H. Pettis
Location

18 (a) Funeral director James A. Sayes
(b) Address 142 W. Third St

19 (a) (b) Huntington Williams, M.D.

APR 9 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-1946 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/6/46 at 22/1.6 P.M.
(b) Where did injury occur? Williams + York sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell into Harbor - drowned

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 4-8-46

39152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafette Ave & John St.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Schlichenmaier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Jacob Schlichenmaier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 Mar 1867

8. AGE: Years	Months	Days	If less than one day
79		26	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Mahle
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Schwartz
15. Birthplace Germany

16 (a) Informant Mrs Melvin J. Connelly
(b) Address 2435 Edmondson St, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. county md.

18 (a) Funeral director Geo. Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) Filed APR 9 - 1946 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 1946, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 April 1946, to 8 April 1946, and that I last saw her alive on 8 April 1946

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Cerebral hemorrhage

Due to Hypertensive cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin J. Connelly M. D.
Address Women's Hosp. Date signed 4/8/46

correct age is especially important. Physicians: please write the

G39153 ✓ G39153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Crawford Home
(c) Hospital or institution: Dennison Street q
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 h Patterson Pk. Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George O Emig

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Cinnie G Emig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12 1868

8. AGE: Years 78 | Months - | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business Owner

FATHER 12. Name George H. Emig

13. Birthplace Germany

MOTHER 14. Maiden Name Anna M. Bahmidt

15. Birthplace Germany

16 (a) Informant Mrs Henry A Emig

(b) Address 1605 h Castle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10 1946 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location North Ave & Rogers St

18 (a) Funeral director Albert L Kilby

(b) Address 1606 h Chester Street

19 (a) APR 9 1946 Registrar Huntington Hollinsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8 1946, at 8 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1946 to Apr 8 1946 and that I last saw h. alive on Apr 6 1946.

Immediate cause of death	Duration
Carcinoma of the Larynx	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richter M. D.

Address 1706 N. Washington St Date signed 4/9/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reg. 639154
5611 Old Pimlico Rd.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 639154 74a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 Pine Brush Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Pine Brush Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. McKay.

3 (b) If veteran, name war 1st W. W.

3 (c) Social Security Account No. 218-09-0404

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary E. McKay

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 24, 1888

8. AGE: Years 57 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county and state)

10. Usual Occupation Stationary Engineer

11. Industry or business Balto City.

FATHER
12. Name John J. McKay.
13. Birthplace Scotland

MOTHER
14. Maiden Name Roulla Berry.
15. Birthplace Virginia

16 (a) Informant Mary E. McKay.
(b) Address 2501 Pine Brush Road

17 (a) Burial (b) Date thereof April 9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Eastern Ave

19 (a) (b)
(Date rec'd by registrar) (Signature of registrar)

APR 9 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1946 to Apr 6 1946
and that I last saw him alive on Apr 6 1946

	Duration
Immediate cause of death: Chronic lymphatic Leukemia	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel H. Culver M.D.

Address 5611 Pimlico Rd Date signed 4-7-46

Samuel H. Culver X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125B

Registered No. G39155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 N. High St
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8da.
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 302 N High St.
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Wilson (Dorothy Dozier)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-13

8. AGE: Years	Months	Days	If less than one day
32	3	11	hr. min.

9. Birthplace Wash D.C
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Louis Dozier
13. Birthplace Wash D.C

MOTHER
14. Maiden Name Susie Marshal
15. Birthplace Wash. D.C.

16 (a) Informant Brother
(b) Address 302 N. High St

17 (a) Burial (b) Date thereof April 10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co, Md.

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) (b)
(Date received) Registrar

APR 9 1946 Washington Williams, Reg.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4-5 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1946 to 4-5 1946 and that I last saw h[illegible] alive on 4-5 1946

Immediate cause of death Resp. failure — Duration

Due to Hepatic disease — undetermined type

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address Mercy Hosp Date signed 4-6-46

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G39156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G39156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133 N. Decker Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A Kirkham
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Benj. J.
6 (c) If dived, give age years
7. Birth date of deceased (mo., day, yr.) April 15 1874
8. AGE: Years 71 | Months 11 | Days 23 | If less than one day 22 hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife
FATHER 12. Name John Herlein
13. Birthplace Germany
MOTHER 14. Maiden Name
15. Birthplace Germany
16 (a) Informant Benj J. Kirkham
(b) Address 133 N Decker Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director John E Moran
(b) Address 3900 E Baltimore St
(c) Signature for Williams M.D. Registrar
APR 9 - 1946 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 12 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to April 7 1946 and that I last saw her alive on April 7 1946
Immediate cause of death Carcinomatosis, abdominal — Duration
Due to Primary site not known
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J J Gould M. D.
Address 47 E 1st Ave Date signed 4-8-46

correct age is especially important. Physicians: please write the

VS 150

2 Trans.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 639157

639157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 S. Parrish St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 S. Parrish St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles W. Garrish

3 (b) **If veteran, name war**

3 (c) **Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Pearl M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6. 1889

8. AGE: Years	Months	Days	If less than one day
56	8	-	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B. & O. R.R.

FATHER 12. Name Henry W. Garrish

13. Birthplace Md

MOTHER 14. Maiden Name Margaret M. Wagner

15. Birthplace Md

16 (a) Informant Mrs. Pearl M. Garrish

(b) Address 409 S. Parrish St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location 2939 Frederick Ave

18 (a) Funeral director Harry F. Weitzel

(b) Address 4161 E. Monument Ave

19 APR 9 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6/46. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Apr 6 1946 and that I last saw h.i.M. alive on April 5 1946.

Immediate cause of death
Carcinoma of Right Lung. — Duration 1-2 yrs.

Due to

Due to

Other Conditions Chronic bronchitis — 4 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Glass. M. D.
Address 876 Wash. Blvd Date signed Apr 8 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G39158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G39158 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2417 Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DRUCILLA B. KESLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William L. C. Kesler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1857

8. AGE: Years	Months	Days	If less than one day
89	1	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name
13. Birthplace Erigeal

MOTHER
14. Maiden Name Balto., Md.
15. Birthplace

16 (a) Informant Susan Ziegler
(b) Address Balto., Md.

17 (a) Burial (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 9 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946, at 8:45A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21, 1946 to Apr 7 1946, and that I last saw h[illegible] alive on Apr 6 1946

Immediate cause of death	Duration
Chr. Myocarditis	
Due to	
Due to	
Other Conditions Senility.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry E. Shannon M.D.
Address 720 Medical Arts Bldg Date signed 4/7/46
M. D.

VS 150

X

639159 381200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

639159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County Bexar
(c) City or town San Antonio
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Melrose - Drive, E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY HINDS NIXON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dr. P. L. Nixon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - 1-31-90

8. AGE: Years 56 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Texas - (Frio Co.)
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Geo. F. Hinds

13. Birthplace Miss

MOTHER 14. Maiden Name Caroline Fountain

15. Birthplace Miss - Records

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location San Antonio, Texas

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) APR 9 - 1946 Huntington Williams M.F.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946 at 2 P.M. 38

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1946 to April 8 1946 and that I last saw her alive on April 8 1946

Immediate cause of death	Duration
Brain Tumor (glioblastoma multiforme) rt. hemisphere	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Inoperable glioblastoma multiforme

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.

Address Date signed

VS 150

correct age is especially important. Physicians: please write the

G39160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G39160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) **FULL NAME** Zenobia C. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Leon Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1881

8. AGE: Years	Months	Days	If less than one day
64	6	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Thadeus Williams
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Ellen Blunt.
15. Birthplace Maryland.

16 (a) Informant Mr. Franklin H Brown
(b) Address 2819 Raynor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/46 (month) (day) (year)
(c) Cemetery or crematory Asbury Cem.
Location Calvert Station

18 (a) Funeral director Thos. J Penny Inc
(b) Address 514 Light St.

19 (a) Huntington Williams, M.H. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 3 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1946 to Apr 6 1946 and that I last saw h[illegible] alive Apr 6 1946

Immediate cause of death

	Duration
(a) Cerebral Hemorrhage	
Due to (b) Terminal	Jan 24 1946
Due to (c) Carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature Leon A Brown
Address 1911 Poplar Grove St Date signed 4/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

APR 9 - 1946

G39161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 G39161 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 Patapsco Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Patapsco Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa M. Anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William L. Anderson
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1858

8. AGE: Years	Months	Days	If less than one day
87	4	28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Louis Fassing
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Beck
15. Birthplace Germany

16 (a) Informant Evelyn M. Anderson
(b) Address 500 Patapsco Ave

17 (a) Burial (b) Date thereof 4/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Magnolia Blvd.

18 (a) Funeral director Chas J. Penny Inc
(b) Address 7 E Eight St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams M.D.

VS 15 APR 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1946, at 3:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1945, to April 6 1946, and that I last saw her alive on April 4 1946.

Immediate cause of death Uremia

Due to Arterio-Sclerotic Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Luban M. D.
Address 320 Patapsco Ave Date signed 4/8/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39162

HB # 100320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G39162

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Druid Hill Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Maude Simms

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1887

8. AGE: Years	Months	Days	If less than one day
59	2	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Simms (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Addison (D)
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Louis P. Gawler
(b) Address 1006 Penna. Ave.

19 (a) (b)

APR 9 - 1946 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1946, at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 2, 1946 to April 5, 1946 and that I last saw h.r. alive on April 5, 1946

Immediate cause of death	Duration
Carcinoma Cervix Uteri, with Multiple Metastases	One yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion M. Lacy M. D.
Address Baltimore City Hospitals Date signed 4-6-46

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39163 G39163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Division St.
(c) Hospital or institution: Provident Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 N Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-0264

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hattie Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day ..... hr. ..... min.
62

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Ephriam Kelly
13. Birthplace Unknown

MOTHER 14. Maiden Name Rachel ?
15. Birthplace Unknown

16 (a) Informant Hattie Kelly
(b) Address 2311 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) APR 9 1946 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1946 to 7/5 1946.
and that I last saw h— alive on 7/5 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 da
Due to Malignant Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Jeffreys M.D.
Address 426 N. Johns Date signed 4/9/46

639164

BALTIMORE CITY HEALTH DEPARTMENT ✓ 639164

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Hospital 2552
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Winwood Ct. Cherry Hill
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Goodman (Goodwin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Leon Goodman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
43 42			hr. min.

9. Birthplace Smoke, S.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Selig Jordan
13. Birthplace Smoke, S.C.

MOTHER
14. Maiden Name P. Thomas
15. Birthplace Smoke, S.C.

16 (a) Informant Leon Goodman
(b) Address 2821 Winwood Court Cherry Hill

17 (a) Burial (b) Date thereof 4-10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St. Huntington Station, Md.

19 (a) (b)
(Date received by registrar) Registrar

APR 9 - 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1946, at 2:25 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Chronic Ulcerative Pulmonary Tuberculosis, bilateral

Due to

Other Condition Tuberculous Peritonitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-8-46

X

AB-~~639~~165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 639165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Estern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 21yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Voley Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12-1897

8. AGE: Years	Months	Days	If less than one day
48	9	24	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jessie (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Betty ? (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Joseph V. Locke, Jr.
(b) Address 1364 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 9 - 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 4-50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5- 1946 to 4-6 1946
and that I last saw him alive on 4-6 1946

Immediate cause of death	Duration
Pneumothorax - spontaneous	2 days
Due to Tuberculosis pulmonary far advanced	2 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Confirms clinical

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Russell Hoffmann M. D.
Address Baltimore City Hosp. Date signed April 8 1946

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39166 well

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157B

Registered No. G39166

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Gilbert Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country –

3 (a) FULL NAME Baby Boy Kerr

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	–

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 27 March 1946

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name Nelson Lasky Kerr
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice Maida Herzog
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Dispatch Hospital
(b) Address

19 APR 9 - 1946 (Date rec'd by registrar) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 March, 1946, at 5:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1946, to 3/29 1946, and that I last saw him alive on 3/29 1946.

Immediate cause of death Respiratory failure due to central anoxia

Due to Spinal Bifida (myelo)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Paul McKinley M. D.
Address 3047 St. Paul St. (Signed)

X

639167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. 639167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NJ (b) County
(c) City or town Trenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 455 W. State St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Phillips, Jesse

3 (b) If veteran, name war

3 (c) Social Security Account No. 560-03-5349

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 19, 1888

8. AGE: Years	Months	Days	If less than one day
57	11	20	hr. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)
10. Usual Occupation Purser & Phlate
11. Industry or business Seafarer

FATHER
12. Name Ferdinand Phillips
13. Birthplace Cincinnati, Ohio

MOTHER
14. Maiden Name Sara Plaut
15. Birthplace Cincinnati, Ohio

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Cremation (b) Date thereof 4.9.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Loudon Bla
Location Balto Md.

18 (a) Funeral director Ward Loudleen & Sons
(b) Address 1902 Eutaw Pl.

19 (a) APR 9 - 1946 Huntington Williams, M.D.
(Signature of registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 9 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1946 to Apr. 9 1946, and that I last saw him alive on Apr. 9 1946.

Immediate cause of death: Adenocarcinoma of descending Colon with metastasis to liver and peritoneum — Duration: UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 4/9/46
US Marine Hospital, Balto, Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 742

G39168 Registered No.

Please answer questions in ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-30-29

8. AGE: Years 16 | Months 15 | Days 4 | If less than one day 8 hr. min.

9. Birthplace Conn (town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name Cary J. Willis
13. Birthplace Va

MOTHER 14. Maiden Name Clara Pendleton
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto County Md

18 (a) Funeral director Mrs. Robert A. Elliott Dugan
(b) Address 1129 N Caroline St.

19 (a) 4-1946 (Date received by registrar) (b) Huntington Willis Mitchell M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946 at 8 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1946 to April 8 1946 and that I last saw him alive on April 8 1946

Immediate cause of death	Duration
Chronic myeloid leukemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Austrian M. D.
Address Johns Hopkins Hosp. Date signed 8 Apr 46

VS 150

G39169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G39169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Bames St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Hines

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1904

8. AGE: Years	Months	Days	If less than one day
42	-	12	....hr. ....min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Walter Hines
13. Birthplace Va.

MOTHER
14. Maiden Name Minerva Johnson
15. Birthplace Va.

16 (a) Informant Mary Hines
(b) Address 1092 126 Ell Nest York

17 (a) Burial (b) Date thereof April 9 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md.
18 (a) Funeral director Jno. Robert G. Elliott Jr.
(b) Address 1099 Druid Park Drive St
19 (a) APR 9 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 9:50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Ulcerative Pulmonary Tuberculosis - bilateral

Due to.....

Other Conditions Ascites, hypertrophy and hyperplasia of liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mellenio M.D.
Medical Examiner.
Date signed 4-6-46

VS 151

G39170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

Registered No. G39170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Poppleton
(c) Hospital or institution: (home)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 So. Poppleton
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Paulina Kriksciunas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16-1859

8. AGE: Years 85 Months 5 Days 23 If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Jacobitis
13. Birthplace Lithuania

MOTHER
14. Maiden Name Veronica Oakunas
15. Birthplace Lithuania

16 (a) Informant Mrs. Anna Martin (sister)
(b) Address 6114 Pimlico Rd. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John J. Conway & Son
(b) Address 2626 Gallows Street

19 (a) APR 9 - 1946 (Date rec'd by registrar) Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1946 at 1:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4/6/ 1946 to 4/8/ 1946 and that I last saw her alive on April 8 1946

Immediate cause of death	Duration
Heart Failure	
following Acute Coronary Thrombosis (onset 4/6/46).	48 hrs.
Due to Coronary Sclerosis	
Due to	
Other Conditions Carcinoma face	15 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Mendelin M.D.
Address 651 N. Bentalou St Date signed 4/8/46.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

94a

G39171 ✓ G39171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Evesham Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Evesham Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE D. O'LAUGHLEN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Maulsby H. O'Laughlen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	10	hr. min.

9. Birthplace Chestertown, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. T. Anderson
13. Birthplace Del.

MOTHER
14. Maiden Name Mary Jane Stephens
15. Birthplace Philadelphia, Pa. -

16 (a) Informant Mrs. C. Maynard Wagner
(b) Address 606 Stoneleigh Rd.

17 (a) Burial (b) Date thereof 4/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) 9 1946 (b) [illegible] Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to April 9 1946.
and that I last saw h[illegible] alive on April 6 19 46

	Duration
Immediate cause of death Heart failure	5 weeks
Due to Chronic Myocardial Failure	15 yrs.
Due to Uremia	3 weeks
Other Conditions Arteriosclerosis generalized	20 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: 4/9/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. O'Donnell M.D.
Address 7201 York Rd. Date signed 4/9/46

G391172 ✓ G391172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200 C

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Edward M. Wood

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1887

8. AGE: Years	Months	Days	If less than one day
59	7	25	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business

FATHER
12. Name Charles J. Woods
13. Birthplace Dublin County

MOTHER
14. Maiden Name Emmeretta Ridge
15. Birthplace Laytonsville Md

16 (a) Informant Mrs. Arthur Wood
(b) Address 1500 Summit Ave, Catonsville Md

17 (a) Burial (b) Date thereof 4-10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville Md

18 (a) Funeral director Wm. J. Tichenor & Sons
(b) Address North and Penn Aves.

DR 4-1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-1946, at 12 10 P.M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: Probably natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Unable to determine because of
Bronchopneumonia
advanced putrefaction.

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Mellenis M.D.
Medical Examiner.
Date signed 4-8-46

G39173 ✓ G39173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Aiken Street
(c) Hospital or institution: 9 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Aiken Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E.Mc Entee Jr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-10-4388

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruby I.Ketnor

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) June 2, 1900

8. AGE: Years 45 | Months 10 9 | Days 5 | If less than one day ###### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Glen Martin

FATHER: 12. Name Joseph E.McEntee
13. Birthplace

MOTHER: 14. Maiden Name Margaret Amos
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ruby I.Mc Entee (Wife)
(b) Address 1715 Aiken Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

APR 9 - 1946 (State registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th, 1946 at 1:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1946, to 4 1946, and that I last saw h[illegible] alive on 4/6 1946

Immediate cause of death: Coronary Thrombosis — Duration: 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sol Smith.

Address 1223 E. North. Date signed 4/8/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G39174 BALTIMORE CITY HEALTH DEPARTMENT ✓ G39174

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 E. Federal Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 E. Federal Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry B. Wendler

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Alice V. Canby

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Dec. 21st., 1860

8. AGE: Years 85 | Months 3 | Days 17 | If less than one day ######## min.

9. Birthplace Pensylvania (Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name Wendler
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Rose Scott (Daughter)
(b) Address 1430 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1946, to 4/7 1946, and that I last saw h/M alive on 4/4 1946

Immediate cause of death Arteriosclerotic Cardio Vascular Renal Disease — Duration 2

Due to

Due to

Other Conditions Gangrene left leg. — Duration 1 week
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J. Blum, M.D.
Address 1206 E. Preston St. Date signed 4/8/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G39175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Laurens St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mattie Locke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Paul R Locke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1880

8. AGE: Years 65 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace St Marys co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hamilton Mason
13. Birthplace St Mary's Co. Md

MOTHER
14. Maiden Name Laura E. Coly
15. Birthplace St Mary Co Md

16 (a) Informant Mrs Huntington P. Locke
(b) Address 1502 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Old York Road

18 (a) Funeral director Wm Brooks
(b) Address 1403 N Carey St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 6 14 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/1946 to 4-7 1946 and that I last saw her alive on 4-7 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension and Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Brooks Jr
Address 1303 N. Fremont Ave Date signed 4/8/46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1946

X

G39176 — BALTIMORE CITY HEALTH DEPARTMENT — Yancey ✓ — G39176

CERTIFICATE OF DEATH

46E — Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Shutter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Mae Yancey
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife William Yancey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1905

8. AGE: Years	Months	Days	If less than one day
40	10	20	hr. min.

9. Birthplace Raleigh N. C. (Town, county, and State)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Green
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Virginia Yancey
(b) Address 813 Shutter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley Ave.

19 (a) APR 9 1946 (b) Washington Williams, M Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1946, to Apr. 7 1946, and that I last saw h[illegible] alive on Apr. 7 1946

Immediate cause of death (a) Respiratory failure — Duration 1 Month

Due to Arteriosclerosis of Lungs, Colon & possible Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard J. Crow, M. D.
Address University Hospital Date signed Apr. 7, 1946

G39177 HEISER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G39177 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Forth & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7303 Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Heiser, Robert Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Alta Heiser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
60	"		hr. min.

9. Birthplace W Va. (Town, county, and state)

10. Usual Occupation Telegraph Operator

11. Industry or business

FATHER: 12. Name Robert Lee Heiser
13. Birthplace Wheeling West Va

MOTHER: 14. Maiden Name Margaret Cruttaker
15. Birthplace Wheeling West Va

16 (a) Informant Mrs Alta Heiser
(b) Address 7303 Park Drive Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-46 (month) (day) (year)
(c) Cemetery or crematory Green Hill
Location Morgantown West Va

18 (a) Funeral director L. J. Brock
(b) Address 5305 Harford Rd

APR 9 - 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 8 - 1946, at 2.57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 1945 to 4-8-1946 and that I last saw h/ll alive on 4-8-1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Coronary Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. B. Schreiber

Address 57 S. Fulton Ave Date signed 4-9-46

X

Complete all items as far as age is especially important. Physicians: please write the causes of death clearly and legibly.

G39178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G39178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 S. Sharp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No 1035 S. Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carrie Honey Bud Williamson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5-1905

8. AGE: Years	Months	Days	If less than one day
40	8	3	hr. min.

9. Birthplace Ellaville, Ga. (Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER
12. Name Handy James
13. Birthplace Ga.

MOTHER
14. Maiden Name Arie Joynes
15. Birthplace Ga.

16 (a) Informant Arie James
(b) Address 1035 S Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem.
Location

18 (a) Funeral director James & Stays
(b) Address 142 Westell St

19 APR 10 1946 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946, 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21 1946 to April 8 1946 and that I last saw him alive on April 7 1946.

Immediate cause of death: Miliary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Howell M. D.

Address 601 N. Carrollton Ave. Date signed 4/9/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G39179 Batts ✓ G39179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto Gen'l Hosp. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ratts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1908

8. AGE: Years 38 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Basil Batts
13. Birthplace N. C.

MOTHER 14. Maiden Name Augusta Fisher
15. Birthplace N.C.

16 (a) Informant Husband.
(b) Address

17 (a) Removal (b) Date thereof 4-10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Winston Salem
Location North Carolina

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 1601 Montgomery St

19 (a) Huntington Williams M.D.

APR 10 1946
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1946, at 10½ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1946, to 4-9 1946, and that I last saw h[illegible] alive on 4-9 1946

Immediate cause of death Uremia — Duration

Due to Chronic Glomerulo-nephritis with hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1213 Light St Date signed 4/8/46

S. B. G. H.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G39180 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 McCulloch
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) FULL NAME Annie Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-5297

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-1906

8. AGE: Years 40 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Danville Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin McCaden
13. Birthplace Milton N. C.

MOTHER
14. Maiden Name Mamie Crawley
15. Birthplace South Boston Va

16 (a) Informant Howard McCaden
(b) Address 1606 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-18-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem,
Location Baltimore Md

18 (a) Funeral director Mayfield & Galt
(b) Address 2101 McCulloch St

19 (a) APR 10 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1946 at 2.09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1946 to 4-7 1946, and that I last saw h.e alive on 4-7 1946.

Immediate cause of death cerebral Hemorrhage (massive) — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1207 Hamilton Ave Date signed 4/10/46

VS 150

X

G39181 Reg. No. 80463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 80E

Registered No. G39181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 0- 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Sarah Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER James Gardiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Carena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17th 1883

8. AGE: Years 62 | Months 11 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Gardiner
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Stephens (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 4-13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 10 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1946 19 , at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20th 19 48 to Apr. 7th 19 , and that I last saw h 1E alive on April 7th 19

Immediate cause of death: Respiratory failure — Duration

Due to Hypertensive cardio-vascular disease

Due to Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Wm. Doyle Waldron M. D.

Address B C H Date signed Apr. 9, 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39182 puer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109 B

Registered No. G39182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5413 Old Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Volumas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1946

8. AGE: Years | Months | Days: 27 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alphonse
13. Birthplace

MOTHER
14. Maiden Name Dora Unger
15. Birthplace Maryland

16 (a) Informant Dora Volumas
(b) Address 5413 Old Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Baltimore

18 (a) Funeral director Frank H Seitz
(b) Address 814 [redacted] 36 St

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

APR 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1946 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1946 to 4/9 1946 and that I last saw her alive on 4/9 1946.

Immediate cause of death: Cardio Resp Failure — Duration

Due to Pneumonia (Left), Emphysema (Rt). Staphylococcus Aureus

Due to Asthma

Other Conditions Premature

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. E. Carmody M.D.

Address St Agnes Hosp Date signed 4/10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G39183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 841 Park Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 841 Park Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME: Julia V. Paul

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Luke Paul

6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1886

8. AGE: Years 59 | Months 6 | Days 15 | If less than one day --hr. ---min.

9. Birthplace: New York (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: -------

FATHER
12. Name: Michael Meade
13. Birthplace: New York

MOTHER
14. Maiden Name: Margaret Campion
15. Birthplace: New York

16 (a) Informant: Margaret R. Meade
(b) Address: 841 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Meade and Son
(b) Address: 805 N. Calvert Street

19 (a) APR 10 1946 Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1943 to April 8 1946 and that I last saw h-- alive on April 4 1946

Immediate cause of death	Duration
Coma	
Cerebro Vascular Accident	
Due to Bronchopneumonia Arteriosclerosis	
Due to Hypertension	
Other Conditions Prostatectomy	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. C. Meade M. D.
Address 1114 W. North Ave. Date signed 4/10/46

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G39184 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 Linden ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Lonza

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Linden ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Jennie Brooks

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-14-8888

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Anderson S.C. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name James Matthews
13. Birthplace S C

MOTHER
14. Maiden Name Sarah Arnold
15. Birthplace S C

16 (a) Informant Nellie Tellington
(b) Address 1613 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) ..... (b) .....

APR 10 1946 Registrar
Huntington Hillsboro, Md.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to April 7 1946 and that I last saw h..... alive on ..... 19.....

Immediate cause of death	Duration
Chronic Nephritis	6 mo
Last disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature W. H. Watt

Address 515 Huntington Ave Date signed 4/9/46

X

G39185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 Q

G39185 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 Webster St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Webster St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Schulz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ferdinand J. Schulz

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 6 - 1877

8. AGE: Years	Months	Days	If less than one day
68	6	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Falbinger
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Dangler
15. Birthplace Baltimore Md.

16 (a) Informant Ferdinand J. Schulz
(b) Address 1623 Webster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director Elizabeth Hartz Funeral
(b) Address 115 E. West St.

19 APR 10 1946 (b) Huntington Williams M.D.
(Date received by Local Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH - 4/8 1946 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to 4/8 1946 and that I last saw h[illegible] alive on 4/8 1946

Immediate cause of death
- Cerebral Hemmorhage — Duration 1 day.
Due to Uremia — 4 hrs.
Due to - Arteriosclerotic Hypertension — 4 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Williams M.D.
Address 1279 Fulton Date signed 4/9/46 M. D.

VS 150

X

G39186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No. G39186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Cleveland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1471 S Dover Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Joseph King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife Mable

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-03

8. AGE: Years 43 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Michael J King
13. Birthplace Pa.

MOTHER
14. Maiden Name Caroline Highber
15. Birthplace Pa

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/46 (month) (day) (year)
(c) Cemetery or crematory Calvary Cemy.
Location Cleveland Ohio.

18 (a) Funeral director John D. Mitchell Home
(b) Address 1960 Euclid Place

19 (a) Apr 10 1946 Arrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1946, to April 10 1946 and that I last saw him alive on April 10 1946.

Immediate cause of death Brain Tumor (glioblastoma multiforme) Duration

Due to Rt. hemiplegia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Brain tumor Rt. hemiplegia

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Antonio Jose Revilla M. D.
Address Johns Hopkins Hosp. Date signed 4/10/46
Antonio Revilla

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G39187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. G39187

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 Lennox Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Lennox Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD M. BOYLAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-6954

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Miriam G. Boylan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/8/1899

8. AGE: Years	Months	Days	If less than one day
46	5	28 29	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Vocational School Instr.
11. Industry or business Baltimore City

FATHER
12. Name Frank L. Boylan
13. Birthplace West Virginia

MOTHER
14. Maiden Name Anna C. McCormick
15. Birthplace Maryland

16 (a) Informant Mrs. Miriam G. Boylan
(b) Address 602 Lennox Street

17 (a) Burial (b) Date thereof Apr. 10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18 (a) Funeral director J. B. Plaskett & Son
(b) Address 1300 Eutaw Place.....8

19 APR 10 1946 (Date received by registrar) Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th. 1946, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26, 1946 to April 4, 1946 and that I last saw h im alive on April 4, 1946

Immediate cause of death	Duration
Probably ventricular fibrillation	
Due to Coronary thrombosis	2 hrs
Due to Hypertensive arteriosclerotic cardiovascular disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ira S. Bayer Jr. M.D.
Address 11 East Chase Street Date signed 4/9/46.

Dr. Ira S. Bayer Jr.

G39188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182 a

Registered No. G39188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Phsp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Govt Vale Farm Emer (If outside city or town limits, write RURAL and give town)
(d) Street No. 69 B. Severeby Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Martz Beury II

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1945

8. AGE: Years	Months	Days	If less than one day
	5	3	hr. min.

9. Birthplace Colorado Springs, Colorado (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Frank Gould Beury
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Anne Wirth
15. Birthplace Chicago, Ill.

16 (a) Informant Mr. William M. Beury, Jr.
(b) Address 63 B Seversky COurt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 10 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946, at 9:20 a. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation
Due to Bed clothes
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 9, 1946 8:15 A. M.
(b) Where did injury occur? 69 B Severeby Ct.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocated by bed clothes

23. Signature Hilton R. Davis M.D. Medical Examiner.
Date signed 4-9-46

G39189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G39189

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 William St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Farrar

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-1973

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virginia Farrar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
about 85			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant Mrs. Graceton Headley
(b) Address 1007 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway A.A. Co.

18 (a) Funeral director Elizabeth Hartle Doe.
(b) Address 115 E. West St.

19 (a) Date received by local registrar APR 10 1946 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946, at 2.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1946 to April 9 1946 and that I last saw him alive on April 9 1946.

Immediate cause of death	Duration
(a) Cerebral Embolism	1 week
Due to (b) Hypertension Arterial	1 week
Due to (c) Arterial Sclerosis	6 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Mellet M.D.
M. D.
Address 1279 Williams St Date signed 4/9/46

639190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

639190 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Newsome

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-19-36

8. AGE: Years 9 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name Ernest Newsome
13. Birthplace Va

MOTHER 14. Maiden Name Betty Wilson
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof April 11 | 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A A County

18 (a) Funeral director Mrs Robert A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 10 1946

US 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1946 to April 8 1946 and that I last saw he alive on April 8 1946

Immediate cause of death Cardiac failure — Duration Hours

Due to Gunshot wound of abdomen, Multiple perforated abscesses

Due to

Other Conditions Retroperitoneal hematoma

(Include pregnancy within 3 months of death)

Date of operation 3-25-46 4-4-46

Major findings of operation Perforated duodenal ulcer, stomach, pancreas, kidney, liver

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3-25-46 at M
(c) Where did injury occur? Baltimore Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? about home (Specify type of place) While at work? No
(e) Means of injury Shot with pistol

23. Signature J.M. Young, M.D.
Address Johns Hopkins Hosp. Date signed 4-9-46

Thomas J. Mascia, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. G39191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Mc Keen Street
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Percy Carson Cassell

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 217-01-6701

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: ?

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1895

8. AGE: Years 50 | Months 5 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Roanoke, Va.
(Town, county, and state)

10. Usual Occupation Packer

11. Industry or business ?

FATHER
12. Name Wm. Cassell
13. Birthplace Roanoke, Va.

MOTHER
14. Maiden Name Ellen Price
15. Birthplace Rocky Mt. Va.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/46 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Frederick Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

APR 10 1946 (Registered by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8 1946, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 3 1946, to Apr. 8 1946, and that I last saw him alive on Apr. 8 1946.

	Duration
Immediate cause of death: Acute myocarditis with right sided heart failure	2 days
Due to: #2- Acute hemorrhagic nephritis	1 wk.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Clinical Director
Address US Marine Hospital, Balto, Md. Date signed 4/9/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G39192 Registered No. (new)

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland
(c) Hospital or institution: Bon + Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6112 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lee Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-8353

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Grace Jones.
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1907

8. AGE: Years	Months	Days	If less than one day: hr.	min.
39 38	4	-		

9. Birthplace Balto - Md
(Town, county, and state)
10. Usual Occupation General Manager
11. Industry or business Jacobs Transfer Co.

FATHER
12. Name Edward Jones
13. Birthplace Hagerstown

MOTHER
14. Maiden Name Lillian Stein
15. Birthplace Baltimore - Md

16 (a) Informant Mrs. Grace V. Jones
(b) Address 6112 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor ave

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 April 1946 at 1:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 April 1946 to 9 April 1946 and that I last saw h / alive on 9 April 1946

Immediate cause of death Lung Failure — Duration

Due to Pulmonary Edema

Due to Pneumonia, Lobular

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester G. Sacco Jr. M. D.
Address Bon Balto Gen Hosp Date signed 4/9/46

VS 150 APR 10 1946 Registrar Washington Metropolitan, Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

639193

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2734 Kingsdale
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 Kingsdale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Eable

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: 6[illegible]

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edward E Eable
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1865

8. AGE: Years 80 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace New York N.Y. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John H Bash
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Doris Brick
15. Birthplace New York

16 (a) Informant Wm Merrill Eable
(b) Address 2734 Kingsdale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11 1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto.

18 (a) Funeral director C. Edward Evans
(b) Address 1400 N Charles St.

19 APR 10 1946 Entered by [illegible] for Williams, M.D., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to April 8 1946 and that I last saw her alive on April 8 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 3-hrs

Due to: Brights disease — 9 yrs

Due to: arterio sclerosis — 9 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred L. Zimmerman M. D.
Address 2858 Harford Rd Date signed 9/9/46

VS 150

G39194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G39194 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 W. Randall St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) about 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 W. Randall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Gerta

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-1487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 8, 1886

8. AGE: Years	Months	Days	If less than one day
59	11	291	hr. min.

9. Birthplace Frankfort, Germany (Town, county, and state)
10. Usual Occupation Inside Machinist
11. Industry or business Sinclair Scott Co.

FATHER
12. Name Antone Gerta
13. Birthplace Germany

MOTHER
14. Maiden Name (?)
15. Birthplace Germany

16 (a) Informant Miss Marie L. Bayline
(b) Address 112 W. Randall St. Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location A.A. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles, Balto. 30, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 10 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1946, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to April 9 1946 and that I last saw him alive on April 8 1946

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions Arteriosclerosis Myocarditis	

Date of operation (Include pregnancy within 3 months of death)
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Schwenck
Address 1337 S. Charles St. Date signed 4/9/46 M.D.

G39195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G39195 Registered No. 7261

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1276 Riviera Av. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren W. Simpson. (Warren W. Simpson)

3 (b) If veteran, name war

3 (c) Social Security Account No. 248-01-8971

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9-1889

8. AGE: Years 57 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Frederick County Md.
(Town, county, and state)

10. Usual Occupation Manager —

11. Industry or business Sales Artificial Limbs

FATHER
12. Name William Simpson
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Susie Null.
15. Birthplace

16 (a) Informant Ella Todd
(b) Address 1276 Riviera Av. —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-1946 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Floyce & Flannery
(b) Address 1116 Light St.

19 (a) APR 10 1946 Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1941 to April 7, 1946 and that I last saw him alive on April 7, 1946. —

Immediate cause of death: Coronary thrombosis.

Due to

Due to

Other Conditions: Carcinoma liver
Third of esophagus.
(Include pregnancy within 3 months of death)

Date of operation April 4, 1946

Major findings of operation: Carcinoma of lower third of esophagus

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Friedman
Address 1319 Light St. Date signed 4/10/46

VS 150

G39196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G39196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sophie Lissewood Diffenderfer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife John Diffenderfer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8th, 1860

8. AGE: Years	Months	Days	If less than one day
85	7	1	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Lissewood
13. Birthplace England

MOTHER
14. Maiden Name Sophie Freyert
15. Birthplace England

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 11 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wendefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 8 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9- 1946, at 5-28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr-1- 1946, to April 9 1946.
and that I last saw her alive on April 8- 1946

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Mitral Stenosis -	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave - Date signed 4/10/46

G39197 ✓ G39197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. _____

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Milford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-1
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Thornton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 2, 1877

8. AGE: Years	Months	Days	If less than one day
69	2	7	hr. min.

9. Birthplace Ware Neck, Gloucester County, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin W. Thornton
13. Birthplace Gloucester County, Va.

MOTHER
14. Maiden Name Catherine Cooke
15. Birthplace Gloucester County, Va.

16 (a) Informant Mr. Julian W. Thornton
(b) Address 3806 Milford Ave.

17 (a) Burial (b) Date thereof Apr. 11, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miles L. Amoss
(b) Address 4510 Liberty Heights Ave.

19 (a) Huntington Williams
(Date received by registrar)

APR 10 1946

VS 150

MEDICAL CERTIFICATION

28. DATE OF DEATH April 9 1946, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to April 1946 and that I last saw him alive on April 9 1946.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Generalized arteriosclerosis	6 yrs.
Due to Asthma (Bronchial)	15 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thos. J. Abbott M. D.
Address 4509 Liberty Hgts Ave. Date signed

X

G39198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G39198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Washington Place
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME THOMAS A. WELSH

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-12-0820

4. Sex Male

5. Color or race white

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary A. Welsh

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Keeper Wine Cellar

11. Industry or business Lord Baltimore Hotel

FATHER
12. Name Alonzo Welsh
13. Birthplace La Plata, Maryland

MOTHER
14. Maiden Name Mary Koons
15. Birthplace Maryland

16 (a) Informant Miss Julia W. Walton
(b) Address Lord Baltimore Hotel

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 4/12/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 N. Eutaw Street Huntington Williams, Mgr

19 (a) APR 10 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946, at 3 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1946, to Apr. 8- 1946, and that I last saw h[illegible] alive on Apr. 8- 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. Atherosclerosis	
Due to	
Other Conditions Hypertension & Cardio-Vascular Disease	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Bacon M. D.
Address 1700 Eutaw Pl. Date signed Apr. 9-46

VS 3

G39199 BALTIMORE CITY HEALTH DEPARTMENT G39199
CERTIFICATE OF DEATH 131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 N. Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar W. LeCompte
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-03-3521

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie C. LeCompte
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1875

8. AGE: Years 70 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Cambridge Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Meats Poultry

FATHER
12. Name Thomas LeCompte
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Evelyn Boswell
15. Birthplace Balto. Md.

16 (a) Informant Annie C. LeCompte
(b) Address 619 N. Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave.

18 (a) Funeral director Wm. C. Miller Sons
(b) Address 2435 E. Oliver St.

19 (a) APR 10 1946 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to April 8 1946. and that I last saw h. alive on April 8 1946

Immediate cause of death
Uremia —
Chronic nephritis
Due to Cardio-vascular-renal
Due to Arterio-Sclerosis
Other Conditions —

Duration
4/7/46
Sept 5/45

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Krumeich M. D.
Address 722 N. Kenwood Ave Date signed 4/8/46

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39200
JL - 99475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G39200
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 15
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 N. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen F. Rudiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Henry (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct . ? 1865

8. AGE: Years	Months	Days	If less than one day
80 ?	? 6	?	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mullen
13. Birthplace Ireland

MOTHER
14. Maiden Name McCann
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Ave.

18 (a) Funeral director John L. Miller, Jr.
(b) Address 2465 E. Oliver St.

19 (a) (b)
(Date received by Local Registrar) Registrar

APR 10 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1946, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23, 1946, to April 8 1946 and that I last saw h er alive on Apr. 8 1946.

Immediate cause of death Respiratory failure

Due to Intra-cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature W. Doyle Walker M. D.
Address B. C. H. Date signed Apr. 8 1946

G39201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G39201 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Greatman St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Greatman (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Michael J. Halloran

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1876

8. AGE: Years 69 | Months 4 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Silver, engraver

11. Industry or business Kirk & Co

FATHER: 12. Name William E. Halloran
13. Birthplace Ireland

MOTHER: 14. Maiden Name Catherine McGlynn
15. Birthplace Ireland

16 (a) Informant Mrs Charles A. Kisey
(b) Address 2901 Greatman St

17 (a) buried (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem.
Location 1300 N. Bentalou St

18 (a) Funeral director Colvin Conway & Son
(b) Address 901-03 Fulton St

19 (a) ..... (Date rec'd by registrar) (b) .....

APR 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/1946 at 4:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to Apr 9 1946 and that I last saw h.... alive on Apr 6 1946.

Immediate cause of death: Coronary Occlusion — Duration ✓

Due to: —

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury —

23. Signature Oliver A. Kalaw Jr M.D.
Address 219 Chesterfield Ave Date signed 4/9/46

G33202 BALTIMORE CITY HEALTH DEPARTMENT G39204
CERTIFICATE OF DEATH 52B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N J (b) County
(c) City or town Carneys Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Georgetown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas R. Graves

3 (b) If veteran, name war	3 (c) Social Security Account No. 145-10-1258

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Harriett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-27-91

8. AGE: Years	Months	Days	If less than one day
54	4 6	12	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Plant Operator
11. Industry or business

FATHER 12. Name Frederick Graves
13. Birthplace Pa

MOTHER 14. Maiden Name Catherine Clark
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 10-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Green Clayton N J
Location New Jersey

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) APR 10 1946 (Date received) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946 at 10 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17 1946 to April 9 1946 and that I last saw him alive on April 9 1946.

Immediate cause of death	Duration
(a) Myocardial failure	3 mos.
Due to (b) Rheumatic Carditis Pericarditis	1 yr.
Due to (c)	
Other Conditions Carcinoma of bladder, metastatic (including pregnancy within 3 months of death)	
Date of operation Jan 24 6	
Major findings of operation Carcinoma Tabes, Phlebitis	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Howard E. Brockman
Address J. H. H. Date signed 4-11-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

AB-639203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. 639203

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos- 11days
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Williams St. zone 30
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) April 5- 1881

8. AGE: Years	Months	Days	If less than one day
65	0	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Brown
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Eliott or Eliot
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Bernard E Harlan
(b) Address 121 E West St

19 (a) Date received (b) Registrar Huntington Williams, M.D.
APR 10 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10- 1946 at 4.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1945 to 4-10- 1946 and that I last saw h im alive on 4-10- 1946

Immediate cause of death
Uremia — Duration 4 days.

Due to Cerebral vascular accident — 3 days.

Due to

Other Conditions Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation 4-4-46

Major findings of operation: Inguinal hernia

of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'neill M. D.
Address Balto. City Hosps Date signed 4-10-46

X

To Be Approved by
G33204 Coroner

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G33204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 S Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 S Ellwood Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Rodney
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife George H
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 13. 1894
8. AGE: Years 51 Months 8 Days 27 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Homework
FATHER 12. Name Bernhardt Peterson
13. Birthplace Sweden
MOTHER 14. Maiden Name Lassie Petersen
15. Birthplace Norway
16 (a) Informant George H Rodney
(b) Address 630 S Ellwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road
18 (a) Funeral director John C Morgan
(b) Address 3000 E Baltimore St
19 (a) (b) (Date received by registrar) Huntington Williamsport Md

APR 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946, at 9:45 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Apr 8 1946, to Apr 9 1946, and that I last saw h[illegible] alive on Apr 9 1946

	Duration
Immediate cause of death: Cerebral Hemorrhage	12 hrs.
Due to Arteriosclerosis	6 yrs.
Due to Hypertensive Cardio-Vascular Renal Disease	6 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Clarence W. LeBoutillier M. D.
Address 601 S. Ellwood Ave. Date signed April 9 1946

Homer J. Lemmis, M.D.

V3 150

To be filled in clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

639205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

639205 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Monument Sts
(c) Hospital or institution Maryland General Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city limits, write RURAL, and give town)
(d) Street No. 2833 N. Calvert St (If Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Winfield Scott Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Annie R. Carter

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept-17-1856

8. AGE: 89 | Months 6 | Days 23 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Joseph Carter
13. Birthplace Virginia

MOTHER
14. Maiden Name Louisa Don'Adler
15. Birthplace France

16 (a) Informant Wilmer C Carter (Son)
(b) Address 2833-N-Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Stewart Mourn Co.
(b) Address 1011 W North Ave. Huntingtown Williams, Md

19 (a) APR 10 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946, to April-9 1946 and that I last saw him alive on April-9 1946.

Immediate cause of death	Duration
Heart Failure	
Due to Arteriosclerosis C-V Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Woolley M. D.
Address 2900 Alameda Blvd Date signed April 9 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 150

G33506 ✓ BALTIMORE CITY HEALTH DEPARTMENT G33506

CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 ROSELAWN AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 ROSELANN AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ADOLPH JOHN WEIGAND

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife AMELIA F. MOESLEIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/1868

8. AGE: Years 77 Months 4 Days 20 If less than one day hr. min. 19

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation CABINET MAKER

11. Industry or business CARPENTER

FATHER
12. Name
13. Birthplace UNKNOWN. WAS AT ST. FRANCIS OF ASSISI

MOTHER
14. Maiden Name
15. Birthplace ORPHANAGE.

16 (a) Informant DAUGHTER AMELIA F. GIER
(b) Address 3010 ROSELAWN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by Local Registrar) APR 10 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1946 at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1946 to 4/9 1946 and that I last saw him alive on 4/8 1946

Immediate cause of death	Duration
CORONARY THROMBOSIS	48 hrs
Due to CORONARY SCLEROSIS	2 MOS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Weigand M.D.
Address 6919 Harford Rd Date signed 4/9/46

correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Dr. Alessi G33207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 B

Registered No. G33207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 Southern Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Southern Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward Max New

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary G. New
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1880

8. AGE: Years	Months	Days	If less than one day
66	1	2	hr. min.

9. Birthplace Middlesex Co. Virginia
(Town, county, and state)
10. Usual Occupation Monumental Works
11. Industry or business

FATHER
12. Name William G. New
13. Birthplace Virginia

MOTHER
14. Maiden Name Nanny Good
15. Birthplace Virginia

16 (a) Informant Mr. George H. New
(b) Address 2909 Southern Avenue 14

17 (a) Burial (b) Date thereof 4/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Christ Church Cem.
Location Middlesex Co, Va.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) APR 10 1946 (b)
(Date rec'd by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th, 1946, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1946, to April 9 1946, and that I last saw h alive on April 9 1946.

Immediate cause of death	Duration
Pulmonary edema	2 days
Fat. adv. Chron. arthritis, multiple	10 yrs
Due to malnutrition	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed 4/10/46

Huntington Williams, M.D.

G39208 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G39208
CERTIFICATE OF DEATH 157M Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G39209 BALTIMORE CITY HEALTH DEPARTMENT G39209
CERTIFICATE OF DEATH 46E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Balto.~~ Baltimore
(c) City or town ~~Baltimore~~ TOWSON
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 West Pa. Ave. Towson 4
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Harris (Grace)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, (widowed) or divorced.
6 (b) Name of husband or wife Harry A. Harris
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 21, 1887
8. AGE: Years 58 | Months 9 10 | Days 12 18 | If less than one day hr. min.
9. Birthplace Upper Falls, Balto. Co., Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home
FATHER 12. Name Mr. George Edward Wright (D)
13. Birthplace Md.
MOTHER 14. Maiden Name Alice Ledley (D)
15. Birthplace Md.
16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 1946 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Maryland
18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland
19 (a) (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH April 9 1946, at 2.55 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1946, to April 9 1946, and that I last saw her alive on April 8 1946.

Immediate cause of death	Duration
Cardio-vascular failure	
Due to Intestinal obstruction	
Due to Ca of the uterus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 9, 1946
Major findings of operation: Intestinal obstruction & Ca of the uterus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. P. Constable Jr. M. D.
Address Union Memorial Hosp. Date signed April 9, 1946

APR 10 1946
Huntington Williams, M.D.

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Coroner's certificate is especially important.

G39210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ G39210

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 616 N University Pkwy

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 616 N University Pkwy

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Elizabeth Stewart

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widow

6 (b) Name of husband or wife Wm H Stewart

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 15-1848

8. AGE: Years 98 | Months 7 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Carlisle Penna (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Hamilton McAffie

13. Birthplace Penna

MOTHER 14. Maiden Name Martha McClintock

15. Birthplace Penna

16 (a) Informant Mrs K. R. Hale

(b) Address 616 N University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11-1946 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Bertram D Tate

(b) Address 2234 Kloman St

19 (a) APR 10 1946 (Date rec'd by registrar) (b) Registrar for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1946 at 10 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to April 9th 1946; and that I last saw h[illegible] alive on April 6th 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage.	
Due to Arteria Sclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Wesley Webb M. D.

Address 3005 St Paul St. Date signed 4-10-46

VS 2

X

HEALTH DEPARTMENT—CITY OF BALTIMORE

G39211 **CERTIFICATE OF DEATH** 83a G39211

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4809 Liberty Heits, Ave. St. 8 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME IDA B DENNY

If U.S. Veteran specify WAR

(a) Residence: No. 4809 LIBERTY HEITS AVE St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	WIDOWED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of CHARLES G DENNY

6. DATE OF BIRTH (month, day, year) FEB 24 1860

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
86	1	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. NONE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) VIRGINIA

FATHER

13. NAME JOSEPH S. MITCHELL

14. BIRTHPLACE (city or town) (State or country) VIRGINIA

MOTHER

15. MAIDEN NAME FANNIE J. NEAL

16. BIRTHPLACE (city or town) (State or country) VIRGINIA

17. INFORMANT MR. C. SHERMAN DENNY
(Address) 3020 GUILFORD AVE

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~
Place MT. OLIVET Date 4/11 1946

19. UNDERTAKER JOHN F. DENNY, INC.
(Address) 715 LIGHT ST.

20. FILED APR 11 1946, 19... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Apr 8, 1946

22. I HEREBY CERTIFY, That I attended deceased from Apr ..., 19.46, to Apr 8, 19.46

I last saw h[illegible] alive on Apr 7, 19.46 Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	1946
Secondary to Apr 3.46	Apr 3

Other contributory causes of importance:

Arteriosclerosis	1934

Was an operation performed? ... Date of ...

For what disease or injury? ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) G. C. Sherman M. D.

(Address) 4809 Liberty Heights Ave

OCCUPATION is very important. See instructions on back of certificate.

Huntington Williams, M.D.

G39212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G39212 Registered No.

Write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write t

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2012 Bank st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Bank st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence Behrens

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-9753

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Helen Behrens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1923

8. AGE: Years 22 | Months 9 | Days 23 27 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Chauffeur on truck.

11. Industry or business

FATHER
12. Name John Behrens
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Pearl A Dages
15. Birthplace Baltimore Md.

16 (a) Informant Helen Behrens
(b) Address 2012 Bank St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11 1946 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet
Location Oldnell st

18 (a) Funeral director Kendall Kippiel
(b) Address 812 S Hanover st Baltimore, Md.

19 (a) 4-10 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 6.15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 7 1946 to April 7 1946, and that I last saw him alive on April 7 1946

Immediate cause of death: Acute Cardiac Dilatation — Duration: —

Due to:

Due to:

Other Conditions: Lobar Pneumonia — Duration: 1 Day

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J Kavanagh M.D.
Address 3318 W Eldorado St Date signed 4-10-46 M. D.

For S.J.R. Davis, by Howard Rawlins M.D.

39213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 39213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 W. Lombard st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Marie G. Perkins

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 6th 1893

8. AGE: Years: 52 | Months: 9 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Stenographer
11. Industry or business: State of Md.

FATHER
12. Name: James Parkins
13. Birthplace: Howard Co. Md.

MOTHER
14. Maiden Name: Jennie McColgan
15. Birthplace: Md.

16 (a) Informant: Gladys M. Schreiber
(b) Address: 1921 W. Lombard St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/13/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St

19 (a) APR 11 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10-1946 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions Intracranial Hemorrhage.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-8-46 at 2:15 P.M. 19/4
(b) Where did injury occur? 1841 W. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no.
(d) Means of injury Fell down steps.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 4-10-46

639214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

Registered No. 639214

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 N. Duncan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 N. Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles C. Johnson

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: May E. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5th 1890

8. AGE: Years: 56 | Months: 2 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Tuc Roter
11. Industry or business: Self

FATHER
12. Name: Francis M Johnson
13. Birthplace: Balto Md.

MOTHER
14. Maiden Name: Louisa Ruhl
15. Birthplace: Balto. Md.

16 (a) Informant: May E. Johnson
(b) Address: 1736 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)
(c) Cemetery or crematory: Balto
Location: Md

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

APR 11 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1946, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to April 9 1946 and that I last saw h/h alive on April 8 1946

Immediate cause of death: Carcinoma of Larynx — Duration ?

Due to:

Due to:

Other Conditions: Cerebro-Vascular Hemorrhage — ?
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Joseph S. Blum M.D.
Address: 1206 E. Preston St Date signed 4/9/46

VS 150

G39215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G39215 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2141 Penrose Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2141 Penrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Harry Mangold

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marion L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1880

8. AGE: Years 65 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Clerk - City Hall
11. Industry or business City of Balto.

FATHER
12. Name Henry Mangold
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia De Balz
15. Birthplace Unknown

16 (a) Informant Marion L. Mangold
(b) Address 2141 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 APR 11 1946 (Date rec'd by Registrar) Hastings for Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1946, at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1944 to 4/9 1946 and that I last saw him alive on 4/9 1946.

Immediate cause of death: Coronary Thrombosis — Duration 2 hr.
Due to: Arteriosclerosis
Due to:
Other Conditions: Pulmonary Edema (old)
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Agnes E. Bogard M.D.
Address 1905 W. Balto St. Date signed 4/9/46.

G39216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G39216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 N. Wolfe st
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(d) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 N. Wolfe st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna G. Macauley

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: xxx

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband: Edward E. Macauley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21st 1887

8. AGE: Years	Months	Days	If less than one day
58	7	19	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name James E. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Clara North
15. Birthplace Md.

16 (a) Informant Edward Macauley
(b) Address 1610 N. Wolfe st.

17 (a) Burial (b) Date thereof 4/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) APR 11 1946 (b)
(Date rec'd by Registrar) Registrar

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th 1946, at 11:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1946 to April 10 1946 and that I last saw her alive on March 9 1946.

Immediate cause of death: Cardiac Decompensation — Duration: 1 Day

Due to: Acute Emphysema - Arterial Hypertension — 1 yr

Due to: Interstitial Nephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature Albert Eisenberg M. D.
Address 2025 E. Hoffman Date signed 4/10/46

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

639217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 639217

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers
(c) Hospital or institution: Home for the Aged & Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M Knott

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W	none	Female	White	Widow

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1855

8. AGE: Years	Months	Days	If less than one day
91	2	0	hr. min.

9. Birthplace Frederick Co Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Clay
13. Birthplace Frederick Co Md

MOTHER
14. Maiden Name Caroline Kieffer
15. Birthplace Germany

16 (a) Informant Virginia Savage
(b) Address 2211 Rogers Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director Nelson Oh Son
(b) Address 1219 E Fort Ave
19 (a) APR 11 1946 (Date rec'd by registrar) (b) Huntingtown Millington, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 4:05 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to April 9 1946 and that I last saw him alive on April 9 1946.

	Duration
Immediate cause of death Myocardial Insufficiency	10 days
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur J Davis M. D.
Address 800 W 32nd St Date signed 4-10-46

VS 150

639218 BALTIMORE CITY HEALTH DEPARTMENT 639218

CERTIFICATE OF DEATH 83 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Iowanda Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-2024

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Frank Sachs
13. Birthplace Russia

MOTHER
14. Maiden Name Metta -
15. Birthplace Russia

16 (a) Informant Mrs. M. W. Jacobson
(b) Address 4204 Ethelrod Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-46 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Levin Bro
(b) Address 1439 E Balto St

19 (a) APR 11 1946 Registrar
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MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1946, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions Bronchopneumonia - chronic

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 4-10-46

X

G39219 ✓ G39219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Rutland
(c) Hospital or institution: West Balto Gen. D
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Pulaski St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles M. Hex

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 213-10-0934

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rosinda L Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1904

8. AGE: Years 41 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Bus Operator

11. Industry or business Retired

FATHER 12. Name Charles L. Miller

13. Birthplace New York

MOTHER 14. Maiden Name Caroline Roop

15. Birthplace Maryland

16 (a) Informant Rosinda L. Miller

(b) Address 305 S. Pulaski St.

17 (a) Burial (b) Date thereof 4-13-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Lizzie L. Schwab

(b) Address 2101 Frederick Avenue

19 APR 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 1946, at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 March 1946 to 10 April 1946 and that I last saw h/ alive on 10 April 1946.

Immediate cause of death Uremia — Duration

Due to

Due to Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter A. Ward M. D.

Address West Baltimore Gen. Hosp. Date signed 4/10/46

VS 150

AB-10063 C33220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134B

Registered No. C33420

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Clayton and Fairview -zone6
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oswald H. Fritzsche

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-2669

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gertrude Fritzsche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4- 1868

8. AGE: Years 78 | Months 2 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frederick Fritzche
13. Birthplace Germany

MOTHER 14. Maiden Name Fredericka Wilhelmina
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) ... (Date rec'd by registrar) (b) ...

APR 11 1946

Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 9- 1946 at 5.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26- 1946 to 4-9- 1946 and that I last saw h. in alive on 4-9- 1946

Immediate cause of death Terminal bronchopneumonia lobular
Due to Pyelonephritis
Due to
Other Conditions Uremia

	Duration
	3 Days
	2 mos
	4 days

(Include pregnancy within 3 months of death)
Date of operation 4-3-46
Major findings of operation: Bladder calculi
of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orwell M. D.
Address Balto. City Hosps Date signed 4-11-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39221 G39221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline
(c) Hospital or institution:
St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Ds
(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Catasauqua.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 First St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Irene P. Groman — Irene P. Groman

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ##### 5/7/1923

8. AGE: Years 22 | Months ### | Days II | 4 | If less than one day ######### min.

9. Birthplace Catasauqua Penn
(Town, county, and state)

10. Usual Occupation Office Clerk

11. Industry or business Social Security Board

FATHER
12. Name Frank Groman
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Antosh
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Raymond Acker
(b) Address 2549 Robb Street, Balto: Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Catasauqua, Pa.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue
Huntington Williams, Mgr.

19 (a) Date rec'd by ~~APR 1 1946~~ (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1946, at 6.40 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/1946 to 4/11/1946, and that I last saw he alive on 4/11/1946

Immediate cause of death: Accidental

	Duration
Due to: Diabetes Mellitus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Harmon M. D.
Address St. Joseph's Hospital Date signed 4/11/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G39222 G39222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Schaus

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	212-09-0793

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 12, 1878

8. AGE: Years	Months	Days	If less than one day
67	10	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerical work
11. Industry or business Hathaway Co.

FATHER
12. Name Charles B. Schaus
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Florence E. Armiger
15. Birthplace Balto., Md.

16 (a) Informant Mrs. C. W. Himmelsbach, sister
(b) Address 2801 Garrison Blvd.

17 (a) Burial (b) Date thereof 4 / 12 / 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) (b)
Registrar

APR 13 1946

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Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1946, at 2 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions Fractured femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 2-21-46 at 6 30 P.M.
(b) Where did injury occur? Belair Rd. & Gorsuch Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto. while alighting from street car

23. Signature Howard J. Thalheimer M.D.
Medical Examiner.
Date signed 4-10-46

JERMANAKOS

G39223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

430 Registered No. G39223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County:
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Radnor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Lawrence Jermanakos

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elsie

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 190?

8. AGE: Years 41 | Months 5 23 | Days 4 22 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation waiter

11. Industry or business Lunch Room

FATHER 12. Name Christ Jermanakos

13. Birthplace Greece

MOTHER 14. Maiden Name Joanne Packeros

15. Birthplace Greece

16 (a) Informant Wife Elsie

(b) Address 506 Radnor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1946 (month) (day) (year)

(c) Cemetery or crematory Greek Orthodox Cem.

Location Baltimore, Md.

18 (a) Funeral director Maynard D. Covington

(b) Address 21 W. 25th St.

19 (a) (b) Registrar

APR 11 1946

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 1946, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 6:30 P M 1946, to 4/8 10:45 P M 1946 and that I last saw h. alive on 4/8 1946.

Immediate cause of death: Respiratory failure

Due to: Cerebral Hemorrhage

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Wat Hollyes M. D.

Address Date signed

Huntington Williams, M.D.

(over)

X

G39224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G39224

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only authorized abbreviations. Do not use ditto marks. Any necessary supplies. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Nedm
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Enos

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-1898

8. AGE: Years 48 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace Kansas (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Howard Price

13. Birthplace Kansas

MOTHER 14. Maiden Name Florence ?

15. Birthplace Kansas

16 (a) Informant Record

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 14, 1946 (month) (day) (year)

(c) Cemetery or crematory Black Rock

Location Butler Balto. Co., Md.

18 (a) Funeral director Landon M. Ensor

(b) Address Sparks, Md.

19 (a) (Date rec'd by registrar) (b) Hunting Williams, M.D.

APR 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1946 Apr 10 1946 and that I last saw her alive on April 10 1946

Immediate cause of death: Peritonitis and cachexia — Duration

Due to Intestinal Infarction with subsequent resection of gangrenous intestine

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 25, 1946

Major findings of operation April 1, 1946

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Whitridge Williams M.D.

Address Johns Hopkins Hospital Date April 11, 1946

X

G33225 GRACZYK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G33225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dow.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Victoria Graczyk

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business — Home

FATHER
12. Name Paul Graczyk
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria Samson
15. Birthplace Poland

16 (a) Informant Stanislaw Graczyk
(b) Address Butler Rd., Reisterstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Duke & Azazarets
(b) Address 1931 Eastern Ave.

APR 11 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1946 at 11 45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-9-46 (?) at 2-3 M.
(b) Where did injury occur? Found: - Harbor - Foot of Fleet St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-11-46

G39226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G39226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Ulman Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Ulman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Kolodner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rebecca Nee Mednick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Real Estate

FATHER
12. Name Fahvil Kolodner
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Mednick
15. Birthplace Russia

16 (a) Informant Rebecca Kolodner
(b) Address 2603 Ulman Ave

17 (a) Burial (b) Date thereof April 11, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Cem
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 11 1946 Huntington Williams, MD

MEDICAL CERTIFICATION 3.40

20. DATE OF DEATH April 10, 1946 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to April 10 1946, and that I last saw h alive on 4/10 1946

Immediate cause of death Bronchopneumonia — Duration 3 Days
Due to Chronic Coronary Insufficiency — 2 yrs.
Due to Hypertension — 5 Years.
Due to Cardiac Hypertrophy
Due to Cardiac Decompensation

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Newton Cooper M. D.
Address 7201 Eastern Ave Date signed 4/11/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39227

5106 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G39227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3311 Batavia Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Batavia Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Harriet Nixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife George Nixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1861

8. AGE: Years	Months	Days	If less than one day
85	2	30	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Emma Nixon
(b) Address 3311 Batavia Avenue 14

17 (a) Burial (b) Date thereof 4/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 APR 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th, 1946, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1946 to April 9 1946, and that I last saw her alive on April 4 1946.

Immediate cause of death Coronary Occlusion — Duration

Due to Hypostatic pneumonia, cardiac insufficiency, diabetes mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Henry Haase M. D.
Address 5106 Harford Rd. Date signed April 11 1946

Dr. Janny

G39228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G39228

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Woodhome Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Woodhome Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Betty Siebert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John L. Siebert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1863

8. AGE: Years	Months	Days	If less than one day
82	4	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles F. Edlinger
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Hattzman.
15. Birthplace Germany

16 (a) Informant Mrs. Helan Richards
(b) Address 3019 Woodhome Avenue 14

17 (a) Burial (b) Date thereof 4/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) APR 11 1946 Huntington Williamsville
(Date received by Registrar) (b)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th, 1946, at 6:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19; and that I last saw her alive on April 9, 1946.

Immediate cause of death	Duration
Coronary Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Janney M. D.
Address 7101 Harford Rd Date signed 4/10/46

For C. J. Lubunski, M. D. by Howard J. Wallace, M.D.

G39229 over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G39229 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Nelson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 46

8. AGE: Years	Months	Days	If less than one day
			2 hr. 10 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Orval D. Nelson
13. Birthplace Burnside, Texas

MOTHER
14. Maiden Name Evelyn Rose King
15. Birthplace Lindbergh, Texas

16 (a) Informant Mrs. Orval D Nelson
(b) Address Baltimore Maryland

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof 4/8/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J Ruck
(b) Address 3345 Hayford Road Huntingtown Williams, Md.

19 (a) APR 11 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/46 19 , at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/46 19 to 4/7/1946, and that I last saw him alive on 4/6/ 1946.

Immediate cause of death: Otitis Media
Interval between onset and death — Primary Cause
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Georgia M. Harrison M. D.
Address St. Josephs Hospital Date signed 4/9/46

VS 150

G39230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 W. Mulberry St.
(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) all his life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME WONG ARK Lee Sing

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: Chinese
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Not known
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) abt - 1870

8. AGE: Years 76 | Months ? | Days ? | If less than one day: hr. min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation Restaurant
11. Industry or business Retired

FATHER
12. Name Not known
13. Birthplace China

MOTHER
14. Maiden Name Not known
15. Birthplace China

16 (a) Informant Wm. Lee - Nephew
(b) Address 702 Light St. - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk.
Location Woodlawn Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOOSER SUC.) 105 W. NORTH AVENUE

19 APR 11 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 5? P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1940 to April 10 1946, and that I last saw him alive on April 10 1946.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	10 yrs.
Due to Senility	10 yrs.
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. V. Chesnutt M.D.
Address 610 York Rd. Date signed April 10 1946

correct age is especially important. Physicians: please write the

VS 150

G39231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G39231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Morgue (700 Fleet St
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County.....
(c) City or town Wolfe Summit
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward Lee Hurst

3 (b) If veteran, name war W.W.II in U.S. Navy. | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
23			hr. min.

9. Birthplace: (Town, county, and state)
10. Usual Occupation Storekeeper, 2nd class
11. Industry or business U.S. Navy.

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13-46 (month) (day) (year)
(c) Cemetery or crematory Salem W. Va
Location Salem W. Va.

18 (a) Funeral director O'Dea Funeral Home Inc.
(b) Address 4644 York Road

19 (a) APR 11 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1946, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, PROBABLE accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at 4-1 ? M.
(b) Where did injury occur? Found: Pier #5, Harbor
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
Means of injury Found drowned.

23. Signature Thomas J. Williams M.D.
Medical Examiner.
Date signed 4-3-46

X

G39232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G39232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Bloomfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 e Willows Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene V. Ashcroft Dunlap

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13-46 (month) (day) (year)
(c) Cemetery or crematory Hastings
Location Hastings Pa.

18 (a) Funeral director O'Dea Funeral Home Inc.
(b) Address 4644 York Road

19 (a) APR 11 1946 (Date received by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1946 at 10 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Traumatic amputations

Other Conditions Multiple fractures, lacerations, bruise and avulsion of tissues (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-9-46 at M.
(b) Where did injury occur? Kay Highway & Battery Highway
(c) Did injury occur at home, on farm, industrial place, in public place? B. & O. R.R. Prop. While at work? ?
(d) Means of injury Run over by train.

23. Signature Howard J. Mahoney M.D. Medical Examiner.
Date signed 4-10-46

G39233 BALTIMORE CITY HEALTH DEPARTMENT G39233

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 N. Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 N. Bentalou St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bertha M. Levi

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arthur Levi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 1889

8. AGE: Years	Months	Days	If less than one day
57	11	29	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Moyer,
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Rebecca Beantree,
15. Birthplace Richmond Va.

16 (a) Informant Mrs. Arthur Levi
(b) Address 1732 N. Bentalou St

17 (a) Burial (b) Date thereof 4/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth. Hebrew
Location Balto. Md.

18 (a) Funeral director Harry Sondheim & Son
(b) Address 1902 Eutaw Place

APR 11 1946 (b) Huntingtown, Williams, Md.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1940, to April 10 1946, and that I last saw h. alive on April 2 1946

Immediate cause of death	Duration
Intracranial Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions Malignancy breast. (Operated)	1940

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. H. Reese M. D.
Address 23 W. Mt. Royal Ave. Date signed 4/10/46

VS 3

G39234

491357

BALTIMORE CITY HEALTH DEPARTMENT 1

CERTIFICATE OF DEATH 157E

G39234 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Brooklyn. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1951 E. 17th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bonnie Jean Fogelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-35

8. AGE: Years 11 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Brooklyn N. Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Fogelson
13. Birthplace N.Y.

MOTHER
14. Maiden Name Sylvia Fogelson
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)
(c) Cemetery or crematory Beth Moses Cem
Location Long Island, N.Y.

18 (a) Funeral director Harris Shaffer & Son
(b) Address 701 Cathedral Place

19 (a) Date received by local registrar 4-11-1946 (b) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 11 1946, at 2.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1946 to April 11 1946 and that I last saw her alive on April 11 1946.

Immediate cause of death: Pulmonary Edema — Duration

Due to: Heart Failure

Due to: Pulmonary Stenosis (Tetralogy of Fallot)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: April 10 1946

Major findings of operation: Tetralogy of Fallot.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Interne
Johns Hopkins Hospital Date April 11 1946

G33235 G33235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 E. Rembrandt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Spencer.

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-03-7491

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Black.	Sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 2 1894

8. AGE: Years	Months	Days	If less than one day
52 51			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Francis Spencer
13. Birthplace N. C.

MOTHER 14. Maiden Name Katie E.
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (b) Date thereof April 13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cahens Cemetery
Location Norfolk & Va

18 (a) Funeral director E. Wm Brooks
(b) 1946 1463 N. Carey St
(Date rec'd by registrar) (Address)

19 (a) Huntington for Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 9 1946 at 9.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1946, to April 9 1946 and that I last saw him alive on April 9 1946

Immediate cause of death Uremia

Due to arteriolosclerotic nephritis

Due to hypertensive Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Austrian

Address Johns Hopkins Hosp Date signed 9 Apr 46 M.D.

VS 150

correct—age is especially important. Physicians: please write the causes of death clearly and legibly. The

G39236 COLLINS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G39236 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 E. LANVALE STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 EAST LANVALE STREET
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE C COLLINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65	—	—	hr. min.

9. Birthplace BALTO., MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOHN J COLLINS
13. Birthplace IRELAND

MOTHER
14. Maiden Name BRIDGET R. MCDONALD
15. Birthplace IRELAND

16 (a) Informant MRS. LILLIE REED
(b) Address 419 LORRAINE AVE

17 (a) BURIAL (b) Date thereof 4-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM.
Location CITY

18 (a) Funeral director MARK M WIDEFIELD
(b) Address 501 E 22ND STREET

19 (a) (b)
Registrar

APR 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 9TH 1946, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1946, to 4-9 1946 and that I last saw h[illegible] alive on 4-9 1946

Immediate cause of death	Duration
Broncho-pneumonia	1 wk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. J. Ryan M. D.
Address 1800 N. Charles St Date signed 4-10-46

Huntington Williams, M.D.

39237 Found - Lancaster & Eden Sts.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 39237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Found - Harbor - Lancaster & Eden Sts.
(b) Street address
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Unknown
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steven Holack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 45 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY APR 9 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 11 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1946 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above; and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 3-14-46 at 3-2 M.
(b) Where did injury occur? Found - Lancaster & Eden Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Found Drowned

23. Signature Benedict Skiarelis M.D.
Medical Examiner.
Date signed 3-14-46

VS 151

3

X

G39238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

G39238

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town TOWSON (If outside city or town limits, write RURAL and give town)
(d) Street No. N. YORK ROAD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** BABY BOY JACKSON twin # 2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	BLACK	

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-46

8. AGE: Years	Months	Days	If less than one day
—	—	1/2	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name JAMES DANIEL JACKSON
13. Birthplace GLENARM MARYLAND

MOTHER
14. Maiden Name IDA NORRIS
15. Birthplace MARYLAND

16 (a) Informant IDA NORRIS JACKSON
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Locati Johns Hopkins Medical School APR 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.

19 APR 11 1946 (Date received by Registrar) (b) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8 1946, at 1:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1946, to 4-8 1946, and that I last saw h IM alive on 4-7 1946 11:45PM.

Immediate cause of death	Duration
Pulmonary Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bwerkman M. D.
Address University Hosp. Date signed 4/11/46

3413

G39239

BALTIMORE CITY HEALTH DEPARTMENT

CWK-99378

CERTIFICATE OF DEATH

Registered No. G39239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 39- 2- 14-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Pickaloski, or Pickalowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20-1907

8. AGE: Years 39 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Pickaloski
13. Birthplace Europe

MOTHER
14. Maiden Name Ella Burba (D.)
15. Birthplace Europe

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc. Johns Hopkins Medical School APR 11 1946

18 (a) Funeral director Commissioner of Health
(b) Address

APR 11 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1946 to Apr. 4 1946, and that I last saw him alive on Apr. 4 1946.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions Alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Wachs M.D.
Address B C H Date signed Apr 7 46

correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3412

G39240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G39240 Registered No.

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 S. LUZERNE AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 S. LUZERNE AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE HAAKE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: WILLIAM HAAKE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 29 1879

8. AGE: Years 66 | Months 11 | Days 9 10 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name PHILIP MERRYMAN
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name COURTEY
15. Birthplace MD.

16. (a) Informant GEORGE HAAKE (SON)
(b) Address 2815 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 12/46 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lillyazeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) (b) Registrar

APR 11 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 9 1946, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1946, to Apr 9 1946, and that I last saw alive on Apr 9 1946

Immediate cause of death: Acc. cardiac dilatation, chronic myocarditis
Duration: 3 yrs. 2 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 432 N. Patterson Pk. Date signed 4/11/46

X

209 S Chapel

G39241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G39241
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 S. CHAPEL ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. CHAPEL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES PAUL DEVANEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife MARY DEVANEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 14 1881

8. AGE: Years	Months	Days	If less than one day
64	11	11	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business WATCHMAN

FATHER
12. Name JAMES DEVANEY
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ELIZABETH BADER
15. Birthplace BALTO. MD.

16 (a) Informant KATHERINE BAHNER (SISTER)
(b) Address 507 S. CHAPEL ST.

17 (a) BURIAL (b) Date thereof APR. 15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL.
Location ODONNELL ST.

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) APR 1 1946 (Huntington Williams, M.D.)
(Date rec'd 1946) (Registrar) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH APR. 11 1946, at 7/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 26 1945, to APRIL 11 1946, and that I last saw h. 17 alive on APRIL 11 1946

Immediate cause of death CARCINOMA OF PROSTATE WITH METASTASIS TO SPINE — Duration 5/1/45

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Drenga M.D.
Address 209 S. Chapel Date signed 4/11/46

VS 150

G39242 G39242

489532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 Mayfield Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anna Schreffler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Walter
6 (c) If alive, give age 28 years
7. Birth date of deceased (mo., day, yr.) 12-6-18
8. AGE: Years 27 Months 4 Days 5 If less than one day hr. min.
9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Nurse.
11. Industry or business

FATHER
12. Name Phillip Warren
13. Birthplace Pa.

MOTHER
14. Maiden Name Hattie Klein
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/46 (month) (day) (year)
(c) Cemetery or crematory Lynbrook
Location Lynbrook, L.I.
18 (a) Funeral director Walworth Funeral Dir.
(b) Address 1214 St. Paul St.
19 (a) (Date rec'd by registrar) (b) Purington Witherington

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 11 1946, at 5.55 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1946, to April 11 1946 and that I last saw him alive on April 11 1946.

Immediate cause of death — Duration

Eremia — 2 wks
Due to Chronic Nephritis — 6 mos

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Maurice Blanton, M.D.
Address J. H. H. Date signed 4/14/46

APR 13 1946

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G39243
Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 Bolt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Bolt (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Clark

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Sarah E. Clark
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 1, 1881

8. AGE: Years	Months	Days	If less than one day
65	2	7	hr. min.

9. Birthplace: Harford Co Md (Town, county, and state)
10. Usual Occupation: Retired B&O Engineer
11. Industry or business:

FATHER
12. Name: Dont Know
13. Birthplace: " "

MOTHER
14. Maiden Name: " "
15. Birthplace: " "

16 (a) Informant: Mrs Nellie Funk
(b) Address: 1402 Bolt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13, 1946 (month) (day) (year)
(c) Cemetery or crematory: Good Shepherd
Location: Harford Co Md

18 (a) Funeral director: A. Howard Evans
(b) Address: 1408 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

APR 11 1946 Huntington Williams MD

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1946, at 3:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1945 to 4-9-1946, and that I last saw him alive on 4-2-1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	1 yr. ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: A. Ballod M. D.
Address 707 Fort Ave. Date signed 4-10-46

X

639244

AB-100508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. 639244

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3644 Coolidge Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mally

3 (b) If veteran, name war: N

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harvey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25-1909

8. AGE: Years 37 | Months 0 | Days 16 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John Publick
13. Birthplace Czech.

MOTHER
14. Maiden Name Rose Svehali or Ross Suehali
15. Birthplace Czech.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) APR 12 1946 (Date received by registrar) (b) Huntington-Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 1.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10- 1946 to 4-11 1946, and that I last saw her alive on 4-11- 1946

Immediate cause of death: Pulmonary Tuberculosis — Duration 2-3yrs?

Due to:

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: [redacted]
If autopsy: Not Granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Julian R. Kelsey M.D.
Address City Hosp. Date signed 4/14/46

X

G39245 BALTIMORE CITY HEALTH DEPARTMENT G39245
CERTIFICATE OF DEATH 46F Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2363 Mayfield Ave # 13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Hecker Heckert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John M Hecker
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 1898

8. AGE: Years 47 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Henry Sommer
13. Birthplace Balto

MOTHER 14. Maiden Name Margaret Ulrich
15. Birthplace Balto

16 (a) Informant John M Hecker
(b) Address 2368 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto Co Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 APR 12 1946 (Date rec'd by local registrar) Huntington for Williamsport Md (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th 1946 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 22nd 1946, to April 10th 1946, and that I last saw her alive on April 10th 1946

Immediate cause of death	Duration
Peripneumonia Fatty and Cachexia	
Due to Ca of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 9th 1946
Major findings of operation: Ca of liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzales M. D.
Address Maryland G. Hospital Date signed 4/10/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G39246 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 2011 E. Monument St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Anthony H. Uttenreither.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ethel Uttenreither

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1891

8. AGE: Years 54 Months 9 Days 21 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Balto City

11. Industry or business Street Cleaning.

FATHER 12. Name Peter Uttenreither

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Luthardt

15. Birthplace Baltimore

16 (a) Informant 2011 E Monument St

(b) Address Ethel Uttenreither

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15- (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location City

18 (a) Funeral director Ulderich Funeral Home

(b) Address 200 S Paca St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 7:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1946, to April 11 1946, and that I last saw h[illegible] alive on April 11 1946.

Immediate cause of death Cachexia, Dementia

Generalized Carcinomatosis

Due to Bronchogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. H. Bruchmann M. D.

Address Sinai Hospital Date signed 4/11/46

Rec'd APR 12 1946

Please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G33247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Redding

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1946

8. AGE: Years — Months — Days — If less than one day 2 hr. 32 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Sterling Roscoe Redding
13. Birthplace Mullers Station, Carroll Co. Md.

MOTHER
14. Maiden Name Beulah Susan McCullough
15. Birthplace Hampstead, Md.

16 (a) Informant Mother
(b) Address Hampstead, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location

18 (a) Funeral director Jacob Wyatt & Son
(b) Address Manchester Md

19 (a) (Date rec'd by registrar) (b) Registrar

APR 12 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11:50 AM 4/11 1946, to 2:30 PM 4/11 1946, and that I last saw her alive on April 11 1946.

Immediate cause of death: cerebral Hemorrhage — Duration 2 hr

Due to: Birth Trauma

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M.D.
Address Univ. Hosp. Date signed 4/11/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEO M. WILLET

G39248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

G39248 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4216 White Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Leo M. Willett

3 (b) If veteran, name war —

3 (c) Social Security Account No. 176-05-3257

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Bertha D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-3-92

8. AGE: Years 54 | Months - | Days 7 | If less than one day hr. min.

9. Birthplace Pa. McSherrystown (Town, county, and state)

10. Usual Occupation Shoe Manufacturing

11. Industry or business

FATHER
12. Name David Willett
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Rath
15. Birthplace Pa.

16 (a) Informant Beatrice
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) APR 12 1946 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1946 to April 10 1946 and that I last saw h alive on April 10 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia and cachexia.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 28 March 1946
Major findings of operation: Carcinoma of Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John William Hillman M.D.
Johns Hopkins Hospital Date April 16, 46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G39249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 McCulloh
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 McCulloh (If no street give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maine E. Dutton

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1886

8. AGE: Years	Months	Days	If less than one day
59	9	3	hr. min.

9. Birthplace Carter Harford Co. Md
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business Private

FATHER
12. Name Theo Fisher
13. Birthplace Md

MOTHER
14. Maiden Name Amy Scott
15. Birthplace Md

16 (a) Informant Mildred Dutton
(b) Address 1409 McCulloh
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.
18 (a) Funeral director Mrs. Chas. W. Holland
(b) Address 1631 Druid Hill Ave.
19 (a) Registered by (b) Huntington Williams

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/46 1946 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27/46 to 4/9/46 19; and that I last saw h alive on 3/27/46

Immediate cause of death Coronary Thrombosis — Duration 4 days

Contributory Cause Hypertension

Due to Hypertension Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Eric Ellis M. D.
Address 9 W. Franklin St. Date signed 4/11/46
Howard J. Mulderig, M.D. X

639250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. 639250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 McCulloh Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY AUGUSTA DAVIS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1870

8. AGE: Years	Months	Days	If less than one day
75	11	9	hr. min.

9. Birthplace Queen Annes Co. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Augustus Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah K. Johnson
15. Birthplace Md.

16 (a) Informant Sarah E. Foreman
(b) Address Queenstown, Md.

17 (a) Burial (b) Date thereof April 13, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Hallett
(b) Address 1621 Druid Hill Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 12 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9-1946 at 7.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1946 to 4-9 1946 and that I last saw her alive on 4-9 1946

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address 1001 Madison Ave Baltimore Md. Filed 4/10/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G39251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 W Rayner Ave -
(c) Hospital or institution:
West Baltimore Gen Hosp -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 min
(e) Length of stay in Baltimore (yrs., mos., or days) 46 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7922 Elmhurst ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Raemer -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 46 hr. 46 min.

9. Birthplace West Baltimore Gen Hosp
(Town, county, and state)

10. Usual Occupation newborn.

11. Industry or business

FATHER
12. Name Cheistopher Raemer
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Doris Crouse
15. Birthplace Baltimore Md.

16 (a) Informant Christopher Raemer
(b) Address 7922 Elmhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 12 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Loudon Funeral Home
(b) Address 7401 Belair Rd.

19 (a) APR 12 1946 (Date rec'd by Registrar) Huntington Williams M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- April 1946, at 5:46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11/46 1946, to 19, and that I last saw h.i.m. alive on 5-11-46 1946.

Immediate cause of death Cardiac & Respiratory Failure — Duration

Due to Erythroblastosis fetalis

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Enlarged liver (Stated) Jaundice

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ron Silverwood M. D.

Address 7039 Gustavo Place Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

39252 G39252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G39252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Beech Ave.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Beech Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian B. Broyles

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow.

6 (b) Name of husband or wife Wm. L. Broyles
6 (c) If alive, give age (deceased)

7. Birth date of deceased (mo., day, yr.) April 19, 1870

8. AGE: Years	Months	Days	If less than one day
75 68	11	23	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name Newton Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Fanbine Cliff.
15. Birthplace Virginia

16 (a) Informant Elmer E. Broyles.
(b) Address 3304 Beech Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Townsend & Donovan
(b) Address 2415-17 Chestnut Ave

(a) APR 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1946, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Apr 12 1946 and that I last saw h[illegible] alive on Apr 11 1946.

Immediate cause of death	Duration
Oedema of Lungs	48 hrs.
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis. Diabetes (Include pregnancy within three months of death.)	10 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Luckenbaugh
Address 708 E. North Ave Date signed 4/12/46.

X

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use of information should be carefully supplied. Use

639253 | BALTIMORE CITY HEALTH DEPARTMENT | 639253

CERTIFICATE OF DEATH 166

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola T

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6 1899

8. AGE: Years 47 | Months 48 | Days 2 | 3 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation unemployed.

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace ?

16 (a) Informant Viola Jackson Wright

(b) Address 604 Mulberry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 APR 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946 at 12 10 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute peritonitis

Due to bullet wound of abdomen

Other Conditions Multiple bullet wounds

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-7-46 at 11 30 P. M.
(b) Where did injury occur? 963 W. Mulberry St.
(c) Did injury occur at home, on farm, industrial place, in public place? Friend's home While at work? No
(d) Means of injury Shot

23. Signature Thomas J. Mackie M.D. Medical Examiner.
Date signed 4-10-46

VS 151

39254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 39254

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 Mount Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Mount Av
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Nathan Brewer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1875

8. AGE: Years	Months	Days	If less than one day
70	7	10	hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Robert Dodson
13. Birthplace Washington D C.

MOTHER
14. Maiden Name Mahon
15. Birthplace Washington DC.

16 (a) Informant Bessie Matthews
(b) Address 1304 Mount Av.

17 (a) Burial (b) Date thereof Apr 13 194
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md

18 (a) Funeral director Geo. H. Kelly
(b) Address 1303 Presstman St.

APR 12 1946 (b) Huntington Williams M.D.
(Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9 1946, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1945, to Apr 9 1946, and that I last saw h[illegible] alive on Apr 6 1946.

	Duration
Immediate cause of death Cardio Vascular Disease	1 yr.
Due to Broken Compensation	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Williams Jr M. D.
Address 1728 Penna Ave Date signed 4/11/46

G39255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

G39255 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) {8 yrs 7 mos 29 da
(e) Length of stay in Baltimore (yrs., mos., or days) {56 yrs 10 mos 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Gilbertson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1889

8. AGE: Years 56 | Months 7/10 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Milliner

11. Industry or business

FATHER
12. Name George A. Martin
13. Birthplace Baltimore

MOTHER
14. Maiden Name Helen White
15. Birthplace Baltimore

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St

19 (a) APR 12 1946 (Registrar's file no.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12 1937, to Apr. 10 1946, and that I last saw h[illegible] alive on Apr. 10 1946.

Immediate cause of death: Myocardial Infarct — Duration

Due to

Due to

Other Conditions: Involutional Melancholia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel F. Adams M. D.
Address 336 Cathedral St Date signed

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39256

BALTIMORE CITY HEALTH DEPARTMENT G39256

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2227 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kazmiera Rowny

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-3386

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alexander Rowny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23 1896

8. AGE: Years 49 50 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Work At Home

11. Industry or business

FATHER
12. Name John Szalkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Stefania Mielnicki
15. Birthplace Poland

16 (a) Informant Alexander Rowny
(b) Address 2227 Bank St.

17 (a) Burrial (Burial, cremation, or removal) (b) Date thereof Apr. 13. 46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Stanley W. Ozazewski
(b) Address 3030 Eastern Ave.

19 (a) (Date rec'd by registrar) APR 12 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aprial 9 19. 46 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 9 1946 and that I last saw h alive on April 9 1946

Immediate cause of death: Coronary Thrombosis — Duration 4/9/46
Due to Chr Myocarditis — 4/1/44
Due to Hypertension Cardio-Vascular Disease — 4/1/44
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Roarer M. D.
Address 801 n Kenwood Ave Date signed 4/10/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

88

Registered No. G39257

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 Eutaw Place
(c) Hospital or institution: none 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Allie Radcliff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Judd Raddcliff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1875

8. AGE: Years 71 | Months 1 | Days 24 21 | If less than one day ... hr. ... min.

9. Birthplace Mo.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Benjamin F. Ritter
13. Birthplace

MOTHER
14. Maiden Name Sarah Ann
15. Birthplace

16 (a) Informant Bernard Jeffers
(b) Address 1821 Eutaw Place

17 (a) Burial (b) Date thereof 4/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Crematory~~ Lorraine
Location Windsor Mill Road, Baltimore

18 (a) Funeral director John C. Mitchell & Son, Inc.
(b) Address 1960 Eutaw Place

APR 12 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1946 to April 9 1946 and that I last saw h[illegible] alive on April 9, 1946

Immediate cause of death: Cardiac Failure — Duration: Two weeks

Due to: Long Standing Hypertension

Due to:

Other Conditions: Pneumonia - both lungs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Greenfield M.D.

Address 1821 Eutaw Place Date signed 4/12/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

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G39258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G39258 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Linden Ave.
(c) Hospital or institution: none 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Francis W. Parks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Susie E. Langley
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1875

8. AGE: Years: 71 | Months: 2 | Days: 13 | If less than one day: hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name George Parks
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary
15. Birthplace Pa.

16 (a) Informant Susie E. Parks
(b) Address 1714 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/46 (month) (day) (year)
(c) Cemetery ~~Interment~~ Meadowridge
Location Washington Blvd.

18 (a) Funeral director John O. Whitehurst & Son, Inc.
(b) Address 1906 Eutaw Place

19 (a) APR 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to April 11 1946, and that I last saw him alive on April 8th 1946.

Immediate cause of death	Duration
E. Hemorrhage, Heart Insufficiency	about 6
Due to Tuberculosis of the Lungs	10 years
Due to	
Other Conditions Tuberculosis Pericardial Effusion	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Trancott M. D.
Address Lombardy Apts. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

K. Trancott 500 W. Fayette St. -12.30 X

G39259

AB-100583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G39259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No. 105-14-2886

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 25- 1887

8. AGE: Years	Months	Days	If less than one day
58	6	14	hr. min.

9. Birthplace N.Y.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Campbell
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McCarty
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-13-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Hernan Hill Rd., Balto. Co. Md

18 (a) Funeral director Charles L. Zeiler.
(b) Address 3605 Fait Ave.

19 (a) Date rec'd by Registrar APR 12 1946 (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 9- 1946, at 9.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4- 1946 to 4-9- 1946 and that I last saw h[illegible] alive on 4-9- 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration 6 mo.?

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Kelley M. D.
Address City Hosp. Date signed 4-10-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /3B

G39260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 N.Robinson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N.Robinson St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Palma Agnes Elizabeth Foote

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 219-20-6747

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 25th, 1927

8. AGE: Years: 18 | Months: 9 | Days: 16 | If less than one day: ######## hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Assemble Radio Parts
11. Industry or business Elect.Mfgr.

FATHER
12. Name Philip J.Foote
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Myrtle Clemens
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Myrtle Foote
(b) Address 307 N.Robinson Street

17 (a) Burial (b) Date thereof 4/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E.North Avenue

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

(a) APR 12 1946 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th 1946, at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-46 to 4-10 1946 and that I last saw h[illegible] alive on 4-10 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J Gould M. D.
Address 14 N East Ave Date signed 4-12-46

VS 130

correct age is especially important. Physicians: please write the

G39261 ✓ G39261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

Make the causes of death clearly and legibly. Physicians: please write the exact age is especially important. Penalty for refusing to supply information or for supplying false information is a fine of not more than $100.00 or imprisonment for not more than 60 days, or both. (Sec. 251, Art. 27, Annotated Code of Md., 1939 Supp.) This certificate must be filed with the Registrar before burial or removal from the district in which death occurred. (Sec. 250, Art. 27, Annotated Code of Md., 1939 Supp.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Ensor St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Ensor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Guerth Vogt

3 (b) If veteran, name war

(c) Social Security Account No. 212-16-5102

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male.	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11-1869

8. AGE: Years	Months	Days	If less than one day
76	7 S.	029	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Holland Laundry
11. Industry or business

FATHER
12. Name Henry Vogt
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Guerth
15. Birthplace Germany.

16 (a) Informant Mrs. Mathilda Petri
(b) Address 1709. Ensor St

17 (a) Burial (b) Date thereof April 13-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Louden Park Cem.
Location Baltimore Md.

18 (a) Funeral director Inamee Cook, Sypes
(b) Address 1600 W. North ave.

(c) Date rec'd by registrar APR 12 1946 (d) Registrar Huntington Williams M.D.

VS: 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1946 to 4/10 1946 and that I last saw h.m alive on 4/2 1946

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerotic Cardio- — Duration ?

Due to Pneumonia Lobal Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.

Address 1206 E. Preston Date signed 4/12/46

G39262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G39262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4005 Liberty Heights Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 10
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH KEMPEL ROBERTS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1887

8. AGE: Years	Months	Days	If less than one day
59	0	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George M.Roberts
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louisa C. Kempel
15. Birthplace Balto., Md.

16 (a) Informant Miss Bessie James Roberts
(b) Address 4005 Liberty Heights Ave.

17 (a) Burial (b) Date thereof 4/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received (b) [illegible] Registrar

APR 12 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 10, 1946 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1945 to 4/10 1946 and that I last saw h[illegible] alive on 4/10/46

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Uterine Carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
[illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Zack N. Morgan M. D.
Address 40 Read St. Date signed 4/12/46

X

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: Please write.

G33263 ✓ G33263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 569 Presstman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Snowden Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife Daniel Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1897

8. AGE: Years	Months	Days	If less than one day
48	3	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Oliver Snowden
13. Birthplace Va. Md.

MOTHER
14. Maiden Name Sarah Simms
15. Birthplace Balto. Md.

16 (a) Informant Mamie Mason
(b) Address 569 Presstman St

17 (a) Burial (b) Date thereof April 13, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b)
(Signature of registrar)

APR 12 1946
VS Yes

Huntington Williams, Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1946, at 5:54 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1946 to April 9 1946
and that I last saw her alive on April 8 1946

Immediate cause of death	Duration
Lobar Pneumonia	17 Days
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
H. K. PELTEKIAN
23. Signature H. K. Peltekian M. D.
Address 817 Hamilton Ave Date signed April 9/46

X

G39264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G39264

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution:
Hospital for the Women of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore ~~Timonium~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hospital for Women of Md. (If rural give location)
34 Oakway
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Muchler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/7/46

8. AGE: Years	Months	Days	If less than one day
			3 hr. 53 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name John George Muchler
13. Birthplace Plymouth, Penna.

MOTHER
14. Maiden Name Ruth Louise Howell
15. Birthplace Plymouth, Penna.

16 (a) Informant Mother
(b) Address 34 Oakway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo APR 10 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 12 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946, at 6 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7/1946 to 4/7/1946, and that I last saw him alive on 4/7/1946.

Immediate cause of death Respiratory failure — Duration

Due to Poorly formed respiratory center

Due to Prematurity

Other Conditions Congenital absence of Kidneys; Malformed Hands & Feet.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital Absence of Kidneys.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Autopsy Performed

23. Signature Anthony F. D'Paula M. D.
Address Date signed 4/8/46

VS 150

3418

G39265 BALTIMORE CITY HEALTH DEPARTMENT *✓ G39265

CERTIFICATE OF DEATH 33B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Terra Alta
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt # 3
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barolyn Sue Wotring.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-5-45

8. AGE: Years | Months: 10 | Days: 6 | If less than one day: hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bliss Wotring
13. Birthplace W. Va.

MOTHER
14. Maiden Name Marie Houser
15. Birthplace W. Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 4/12/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Terra Alta
Location Terra Alta W. Va

18 (a) Funeral director William Corbin
(b) Address 1217 E. Fayette St

19 (a) APR 12 1946 (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946 at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1946, to April 11 1946, and that I last saw him alive on April 11 1946.

Immediate cause of death	Duration
Influenza meningitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George L Palmer
Address Harrie Nave Nama Date signed 4-12-46

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

Wd. 14 am case
will 163366

BALTIMORE CITY HEALTH DEPARTMENT ✓ G39266
CERTIFICATE OF DEATH 179 × Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wd. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 334 Mason Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Geraldine Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sterling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-25

8. AGE: Years 21 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Shirley Adams
13. Birthplace W. Va.

MOTHER 14. Maiden Name Mary Lear
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 4/12/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Cloy
Location Cloy W. Va

18 (a) Funeral director Wilson Cox Co
(b) Address 121 W. Mt. Royal

19 (a) (Date rec'd by registrar) (b) Registrar

APR 12 1946 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1946 to April 12 1946 and that I last saw h-r alive on April 12 1946.

Immediate cause of death	Duration
SALICYLATE INTOXICATION ACUTE	24 HRS.
Due to	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: hepatic hemorrhage, liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maxwell Williams, M.D. M. D.
Address Johns Hopkins Hospital Date signed 4-12-46

Howard J. Madaxeis, M.D.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G39267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33 Regist. 4412

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G39268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G39268 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 S Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 S Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Benj Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1846

8. AGE: Years 84 | Months 2 | Days 2 | If less than one day hr. 18 min. 62

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Timothy Chisham
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Riggins
15. Birthplace Baltimore

16 (a) Informant Mary Sarost
(b) Address 812 S Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John A Moran
(b) Address 3000 E Baltimore St

19 (a) Date received by Registrar Huntington Williams, M.D.

APR 12 1946

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1946 to Apr. 10 1946 and that I last saw h.. alive on April 9 1946.

Immediate cause of death Chronic Myocarditis

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Tourkey M.
Address 441 S. Ellwood Ave Date signed 4/12/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

CWK-100491 Registered No. G39269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 70- 1- 19-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N. East Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Gottlieb

3 (b) If veteran, name war N
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lewis Gottlieb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1876

8. AGE: Years	Months	Days	If less than one day
70	1	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name George Stord
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) APR 13 1946 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 46 at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 19 46 to April 11 19 46 and that I last saw h. alive on April 11 19 46

Immediate cause of death Respiratory Failure — Duration

Due to Cerebro-Vascular accident.

Due to Arteriosclerotic Ht. Disease.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Fuller M.D.
Address Balt. City Hosps. Date signed 4-11-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

38240 ✓ G39270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 Pelham Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Pelham Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Welsh

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Alexander Welsh
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 26th 1856

8. AGE: Years: 89 | Months: 4 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: At Home
11. Industry or business: Self

FATHER 12. Name: George England
13. Birthplace: Balto. Md.

MOTHER 14. Maiden Name: Susan Drury
15. Birthplace: Balto. Md.

16 (a) Informant: Ada Cormack
(b) Address: 4510 Arabia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

APR 13 1946
Date filed (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1946, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1945, to April 11, 1946, and that I last saw h[illegible] alive on April 11, 1946.

Immediate cause of death	Duration
Uremia	10 days
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, or place)
(e) Means of injury
23. Signature: Ernest Lang, M.D.
Address 16 of 1 N. Broadway Date signed 4/12/46 M.D.

VS 150

G39271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G39271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Sparrow

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~: John Sparrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26th 1878

8. AGE: Years	Months	Days	If less than one day
67	8	15	17 hr. min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business: Self

FATHER
12. Name: John (Unknown)
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Augusta Pecker
(b) Address: 670 W. Fayette St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.
(c) APR 13 1946 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Pain death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Contributing Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. (Medical Examiner)
Date signed 4-12-46

G33672 ✓ G33672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3648 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 4
(d) Street No. 3648 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Anderson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widow

6 (b) Name of husband or wife Gilbert Anderson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 9th, 1880

8. AGE: Years	Months	Days	If less than one day
64	7	-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name William H. Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Otto
15. Birthplace Md.

16 (a) Informant William H. Klein
(b) Address 3648 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F. Denny Inc
(b) Address 714 Light St.

19 (a) Date received APR 12 1946 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1946, at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to April 9 1946, and that I last saw her alive on Mar 9 1946.

Immediate cause of death	Duration (one year)
Chronic myocarditis + Nephritis	
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Ave. Date signed 4-12-46

X

G39273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G39273

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 W. North Ave (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Rebecca graef (graef)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1872

8. AGE: Years	Months	Days	If less than one day
73 75	7	15	hr. min.

9. Birthplace Frostburg, Md. (Town, county and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name — La Rue
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Rebecca Hurst
15. Birthplace Western Maryland

16 (a) Informant Daughter: Mrs. Margaret
(b) Address Smith, 6320 Dogwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month), (day), (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md

18 (a) Funeral director H.K. Coffman
(b) Address Hagerstown, Md.

19 APR 13 1946 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 12 1946 at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1946 to Apr. 12 1946 and that I last saw h[illegible] alive on Apr. 12 1946 at 8:30 P.M.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Cerebral arteriosclerosis	
Hypertension.	
Due to	
Other Conditions Hypertension and Cardiac disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard E. Blumenthal M. D.
Address W. B. G. H. Date signed Apr. 13, 1946

VS 150

G33274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 632

Registered No. G33274

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 E. Monument St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ruth Rosalie Senft

3 (b) If veteran, name war.....

3 (c) Social Security Account No. 219-18-1700

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-24-23

8. AGE: Years 22 | Months 11 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business Payroll clerk

FATHER
12. Name Charles Senft
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lola M. Pentz
15. Birthplace Balto., Md.

16 (a) Informant Charles M. Senft
(b) Address 3000 E. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4026 Belair Road

18 (a) Funeral director Frederick Smith, Inc.
(b) Address 3016 E. Monument Street

APR 13 1946 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Chronic myocardial degeneration
Acute pulmonary edema

Due to.....

Other Conditions Toxic goiter & hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 4-11-46

VS 151

G39275 BALTIMORE CITY HEALTH DEPARTMENT G39275

CERTIFICATE OF DEATH

107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mandy Lee Brockington

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Female — 5. Color or race Colored — 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1 1846

8. AGE: Years | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Manuel Brooks
13. Birthplace Prince George Co. Md.

MOTHER 14. Maiden Name Della Brockington
15. Birthplace Lexington S.C.

16 (a) Informant Mandel Brooks
(b) Address 646 Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
Address 2345 Schroeder St.

19 (a) (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

APR 15 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Thelen M.D. Medical Examiner.
Date signed 4-12-46

VS 151

X

G33276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 C

Registered No. G33276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Sargeant St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Downey

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-07-2783

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Regina Downey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1896

8. AGE: Years 49 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland (Elkridge) (Town, county, and state)

10. Usual Occupation Handy man

11. Industry or business Rivers Copper & Brass

FATHER
12. Name William L. Downey
13. Birthplace Elkridge Md.

MOTHER
14. Maiden Name Agnes Buckingham
15. Birthplace Elkridge Md.

16 (a) Informant Mrs. Regina Downey
(b) Address 1330 Sargeant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 Filed APR 13 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1946 to 4/12 1946 and that I last saw him alive on 4/12 1946.

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Bronchopneumonia	
Due to Cirrhosis of Liver	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas E. Carr Jr. M.D.
Address St Agnes Hosp. Date signed 4/12/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G39277 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3726 Hayward Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ?
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Hayward Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE H. WHITFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife James M. Whitfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1870

8. AGE: Years	Months	Days	If less than one day
75	9	27	hr. min.

9. Birthplace Bedford Co., Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Simon Harclerode
13. Birthplace Bedford Co., Pa.

MOTHER
14. Maiden Name Hettie Stiffler
15. Birthplace Bedford Co., Pa.

16 (a) Informant Miss Hestor C. Whitfield
(b) Address 3726 Hayward Ave.

17 (a) Removal (b) Date thereof 4/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bedford Cemetery
Location Bedford, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by Registrar) Huntington Williams M.D. Registrar

APR 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1946, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21 1946 to Apr. 12 1946, and that I last saw h[illegible] alive on Apr. 11 1946

Immediate cause of death

Chronic Myocarditis — Duration 1940

Due to

Due to Chronic Interstitial Nephritis — Duration 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Boone M. D.
Address 1663 N. Howard St. Date signed 4/12/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G39278

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 N Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N Fulton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William E Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Mary H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1890

8. AGE: Years 55 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace England

MOTHER 14. Maiden Name Not Known
15. Birthplace England

16 (a) Informant Mrs Wm E Brown
(b) Address 105 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-46 (month) (day) (year)
(c) Cemetery or crematory Laurel Rd
Location Baltimore Md

18 (a) Funeral director Geo A Fahey
(b) Address Fulton & Fayette

19 APR 13 1946 (Date received by local registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1945 to April 11 1946 and that I last saw h[illegible] alive on April 11 1946.

Immediate cause of death	Duration
Apoplexy Left Side	1 day
Due to Arthritis Polyarticular	7 mos.
Due to Cardiovascular	7 mos.
Other Conditions	

*(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R. Johnson, M.D.
Address 403 Medical Arts Bldg Date signed 4-13-46

G39279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G39279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4 days
(e) Length of stay in Baltimore (yrs., mos., or days): 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Va. (b) County:
(c) City or town: Irvington
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location):
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Tellis, Thomas Roney

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 25, 1904

8. AGE: Years	Months	Days	If less than one day
42	0	19	hr. min.

9. Birthplace: Irvington, Va.
(Town, county, and state)

10. Usual Occupation: Fisherman

11. Industry or business:

FATHER
12. Name: Roney Tellis
13. Birthplace: Irvington, Va.

MOTHER
14. Maiden Name: Lilly Ione Knight
15. Birthplace: Irvington, Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-18-46 (month) (day) (year)
(c) Cemetery or crematory
Location: Fairmount Va

18 (a) Funeral director: Engels Farley
(b) Address: Fairfax Va

19 APR 18 1946 (b) Registered by: Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 13 1946 at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 9 1946, to Apr. 13 1946, and that I last saw him alive on Apr. 13 1946.

Immediate cause of death	Duration
Pulmonary tuberculosis, far advanced	15 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr, Surgeon M. D.
Address: Clinical Director Date signed 4/13/46
US Marine Hospital, Balto, Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only

G39280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G39280

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Druid Hill Ave
(c) Hospital or institution: 14-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Collins

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/16/1905

8. AGE: Years	Months	Days	If less than one day
40	10	26	hr. min.

9. Birthplace Md (town, county and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER 12. Name Robert Collins
13. Birthplace md.

MOTHER 14. Maiden Name Mandy Bedford
15. Birthplace Md

16 (a) Informant Mary Collins
(b) Address 1807 Druid Hill Ave

17 (a) Burial (b) Date thereof Apr 15, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Wes D. Kefauver
(b) Address 1303 Pulaski

19 APR 13 1946 (b) Huntington Williams M.D.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11 1946, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1946 to 4/11 1946 and that I last saw h[illegible] alive on 4/10 1946.

Immediate cause of death	Duration
Central Atrophy	
Due to Paralysis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burkett M.D.
Address 2 [illegible] Date signed 4/11/46

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G33281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G33281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5605 Green Spring Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 67 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Green Spring Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** MINNIE WIESENFELD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband ~~or wife~~ Hiram Wiesenfeld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 20, 1861

8. AGE: Years 85 | Months | Days 23 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Myers,
13. Birthplace Germany.

MOTHER
14. Maiden Name Jeannette Oswold,
15. Birthplace Germany.

16 (a) Informant Mr. S. B. Myers,
(b) Address 5605 Green Spring Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4.14.46. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnenborn
(b) Address 1902 Eutaw Place.

19 APR 13 1946 Huntington Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th. 1946 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 April 1946 to 12 April 1946. and that I last saw her alive on 11 April 1946.

Immediate cause of death Coronary thrombosis — Duration —

Due to Coronary arteriosclerosis —

Due to Generalized arteriosclerosis —

Other Conditions None —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Hamburger Jr. M. D.
Address 1207 Eutaw Place Date signed

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G39282 BALTIMORE CITY HEALTH DEPARTMENT × ✓ G39282

CERTIFICATE OF DEATH 170C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maine (b) County
(c) City or town Wiscasset (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emerson Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Tanya S. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24-1907

8. AGE: Years 38 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Wiscasset, Maine (Town, county, and state)

10. Usual Occupation Photographer

11. Industry or business

FATHER 12. Name Harold L. Smith

13. Birthplace Maine

MOTHER 14. Maiden Name Susan Frost

15. Birthplace Illinois

16 (a) Informant Lloyd Lowndes

(b) Address Palisades, N.J.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/13/46 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore Md

18 (a) Funeral director Tilhorn Funeral Home

(b) Address 1219 Park Ave

19 (a) APR 13 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 1:00 P M

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured pelvis intra abdominal hemorrhage, fractured femur

Due to

Other Conditions Arteriosclerosis & hernia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury April 12, 1946 11:30 A M (Accident)

(b) Where did injury occur? Route 40 + 91, Finksburg Md.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury collision between auto & truck

23. Signature Howard J. Mueller M.D. Medical Examiner.

Date signed 4-13-46

X

G39283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G39283 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 St Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick G. Finsey

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 213-03-6437

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Finsey

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1879

8. AGE: Years 68 | Months 4 | Days 26 | If less than one day: hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Estimator

11. Industry or business F. O. Schmidt Co

FATHER 12. Name Frederick Schmidt

13. Birthplace England

MOTHER 14. Maiden Name Emma Small

15. Birthplace England

16 (a) Informant Bertha Finsey

(b) Address 1618 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Tillman & Son

(b) Address 1217 St Paul St

19 (a) APR 12 1946 (Date accepted by city registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to April 11 1946 and that I last saw him alive on April 14 1946.

Immediate cause of death: Bronchopneumonia — Duration: 3 days

Due to: Cerebral Hemorrhage

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. L. Glassman

Address 600 Fallsway Date signed 4/12/46

Edward L. X

VS 150

G39284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G39284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 N Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 N Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Kalbshoff

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-10-2052

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louisa C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 11 1886

8. AGE: Years: 60 | Months: 0 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Machinist
11. Industry or business: Gen. Smelting, Refining

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Louisa E Kalbshoff
(b) Address: 1623 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/16/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md

18 (a) Funeral director: Wilson & Son
(b) Address: 1210 E Cold Spring

19 (a) APR 13 1946 Huntington Williams, M.D. Address: 733 August Ct Date signed: 4/10/46

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1946, to 4/11 1946 and that I last saw him alive on 4/11 1946.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	
Due to	
Due to (b) Hypertension	
Other Conditions Acute Uremia	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: A. L. Hometown M. D.

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G39285 ✓ G39285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Union Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina Wilkerson

3 (b) If veteran, name war nil | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard R
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1851

8. AGE: Years 94 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Margaret Denning
(b) Address 1605 Union Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm Corkran
(b) Address 1214 E. Pont St.

19 (a) APR 12 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 4 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1946, to April 12 1946 and that I last saw h SY alive on April 12 1946

Immediate cause of death: Cardio-Renal-Vascular Disease — Duration 1 yr
Due to Gangrene Rt foot — 1 month
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J W Wilson M. D.
Address 617 W. 40th Date signed 4/13/46

VS 150

G39286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G39286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 E Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 E Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C Hallamyer

3 (b) If veteran, name war M | 3 (c) Social Security Account No. xxx

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1876

8. AGE: Years 70 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Anton Bonhana
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Roesing
15. Birthplace Germany

16 (a) Informant Frances M Hallamyer
(b) Address 1014 E Hoffman St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 4/15/46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros Inc
(b) Address 1214 Gay St

19 (a) (Date signed) (b) Huntington Williamsport Md

APR 15 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1946 to April 11 1946 and that I last saw h[illegible] alive on 4/1 1946

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Renal Disease	7
Due to	
Due to	
Other Conditions Bronchial Asthma	3 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L Blum
Address 206 E Preston St Date signed 4/11/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G33487

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Upperco
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DESMOND HOLDRIDGE

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War II	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Holdridge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	25	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)
10. Usual Occupation Editorial Consultant
11. Industry or business Readers Digest

FATHER
12. Name Gerald O. Holdridge
13. Birthplace Catskill, N. Y.

MOTHER
14. Maiden Name Genevieve Vaders
15. Birthplace Bridgeport, Conn.

16 (a) Informant Mrs. Elizabeth Holdridge
(b) Address Upperco, Md.

17 (a) Cremation (b) Date thereof 4/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 13 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 1 P M

21. I certify that I took charge of the remains described above, held an inspection and inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Pelvis, Intra-abdominal Hemorrhage

Due to

Other Conditions Abrasions and Crush Injuries - Lacerations
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 12, 1946 11:30 A.M.
(b) Where did injury occur? Route 40 + 91, Timbaduy
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision Auto + Truck

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 4-13-46

VS 151

G39288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G39288 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Court Rd, Pikesville Md
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Good

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	M.

6 (b) Name of husband or wife Helen M. Good
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1889

8. AGE: Years	Months	Days	If less than one day
56	7	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Lithographer
11. Industry or business Amer. Book Stationery Co.

FATHER
12. Name William A. Good
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Elizabeth Stoddard
15. Birthplace Baltimore, Md.

16 (a) Informant Charles E. Good
(b) Address Old Court Rd., Pikesville

17 (a) Burial (b) Date thereof 4/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 APR 13 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1946, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4- 1946 to 4-13 1946 and that I last saw him alive on 4-13 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Staphylococcus sepsis	
Due to Perforated duodenal ulcer	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert E. May
Address Mercy Hospital Date signed 4-13-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G39289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G39289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5731 Ridgedale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5731 Ridgedale Road,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Holden,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Daniel L. Holden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1881

8. AGE: Years 65 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER
12. Name James Price Holden,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Sue Baker Wright,
15. Birthplace Harford County, Md.

16 (a) Informant Mrs. Herbert A. Crawmer,
(b) Address 5731 Ridgedale Road,

17 (a) Burial (b) Date thereof 4/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Balto. Co. Md.

18 (a) Funeral director C. Vernon Lemmon,
(b) Address 4611 Park Heights Ave.

19 APR 13 1946 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1946 to 4/12 1946, and that I last saw her alive on 4/12 1946

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Arteriosclerosis — 7 7

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel W. Crum M. D.
Address 5611 Old Pimlico Road, Date signed 4/13/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 150

X

G39290 over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G39290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10'21"
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md (If outside city or town limits; write RURAL and give town)
(d) Street No. 1418 Argyle Ave #17 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Baby Girl Nobday

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/11/46

8. AGE: Years	Months	Days	If less than one day
—	—	—	10 hr. 21 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles Henry Nobday
13. Birthplace Glaston, Virginia

MOTHER
14. Maiden Name Bernice Bryant
15. Birthplace Norfolk, Virginia

16 (a) Informant Bernice Nobday (Mother)
(b) Address 1418 Argyle Ave, Balto-17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Baltimore Co, Md.

18 (a) Funeral director Charles L. Cooper
(b) Address 512 N. Carrollton Ave

APR 13 1946 (b) Huntington Williams, MD
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 10 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 40 AM 4/11 1946, to 10 10 PM 4/11 1946, and that I last saw h CY alive on 4/11 1946.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Asphyxia Atelectasis	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Marman M. D.
Address Univ. Hosp. Date signed 4/11/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

639291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. 639291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Lime
(c) Hospital or institution:
University Hospital 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Echodale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donna Carstens

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1946.

8. AGE: Years — Months — Days 25 24 If less than one day hr. min.

9. Birthplace University Hospital, Balto.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Donald H. Carstens
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Ruzicka
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 3616 Echodale

17 (a) Burial (b) Date thereof 4/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Emmanuel Luth. Cem.
Location

18 (a) Funeral director Leonard J. Rush
(b) Address 5305 Harford Rd.

19 (Date received in register) APR 13 1946 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 4 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1946, to April 12 1946, and that I last saw h. alive on April 12 1946.

Immediate cause of death	Duration
Respiratory failure	
Due to Post-operative	
Due to Dyspnea	
Other Conditions Dehydration	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. McCurdy M. D.
Address University Hosp. Date signed April 13 1946

VS 150

C39292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134c

Registered No. C39292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Belgian Ave.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Belgian Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Mary Justis

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Jeremy L. Justis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/46 10/15/70

8. AGE: Years	Months	Days	If less than one day
75	5	28	— hr. — min.

9. Birthplace Balto, Balto, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Joseph Hoffuter
13. Birthplace Germany

MOTHER
14. Maiden Name (Margaret Hoffuter)
15. Birthplace (?)

16 (a) Informant Margaret M Stample
(b) Address 716 Belgian ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wm Cunningham Co & Son
(b) Address 217 St Paul

19 (a) Date rec'd by — 1946 (b) Huntington Williams, M.D. Registrar

APR 13 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1946, at 10 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946, to April 13 1946, and that I last saw her alive on April 12 1946.

Immediate cause of death	Duration
Due to kidney shut down	
Due to uremia calculi	
Other Conditions generalized sclerosis of arteries	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Adams M. D.
Address Bon Secours Hospital Date signed 4/13/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39293 G39293

491557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Fort Roundedale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 N. Victorian Park Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Joseph Grant Peace.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male.	White.	widower.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-17-64

8. AGE: Years	Months	Days	If less than one day
81	8	26	hr. min.

9. Birthplace N.Y.
(Town, county, and state)

10. Usual Occupation Retired Dentist.

11. Industry or business

FATHER
12. Name Joseph M. Peace
13. Birthplace N.Y.

MOTHER
14. Maiden Name Eliza Ann Griffin
15. Birthplace md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 4/13/46
(month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Long Park Ave.

18 (a) Funeral director Fisher & Puckhaber Inc.
(b) Address 4900 Eastern Place

19 APR 13 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1946 to April 12 1946, and that I last saw him alive on April 12 1946.

Immediate cause of death	Duration
Cardiac failure (acute)	
Due to age?	
Due to	
Other Conditions moderate hypertension	

(Include pregnancy within 3 months of death)

Date of operation 4-11-46

Major findings of operation: Cataract L.E. - Traction left Eye.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Hoffman M. D.
Address Johns Hopkins Hosp. Date signed 4-13-46

VS 150

G39294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G39294 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Jud University
(c) Hospital or institution: ~

(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford.
(c) City or town Fallston
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~ (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ~

3 (a) **FULL NAME** Louis AMERIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lucetta L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1877

8. AGE: Years	Months	Days	If less than one day
68	4	3	hr. min.

9. Birthplace Md. (town, county, and state)
10. Usual Occupation Retd Truck Farmer
11. Industry or business M & P R.R.

FATHER 12. Name	Henry Amerin
FATHER 13. Birthplace	Md.
MOTHER 14. Maiden name	Margaret Kauffman
MOTHER 15. Birthplace	Germany

16 (a) Informant Mrs Louis Amerin
(b) Address Fallston Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 16, 46 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Fallston Md

18 (a) Funeral director Earl Grose
(b) Address Benson Md

19 (a) APR 1 1946 (Date received by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 APR. 1946, at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 March 1946 to 13 APR 1946, and that I last saw h[illegible] alive on 13 APR 1946

Immediate cause of death	Duration
Acute Pancreatitis	1½ mos
Abscess Lesser Omentum	10 days
Due to	
Due to	
Other Conditions Nephrosclerosis	

(Include pregnancy within 3 months of death)
Date of operation 4 March 46
Major findings of operation:
Acute Hemorrhagic Pancreatitis
of autopsy Gas above & Omental abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Columbus O. Dane, Jr.
Address Univ. Hosp. Date signed 15 Apr 46

VS 150

G39295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193c

G39295
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G39296 — BALTIMORE CITY HEALTH DEPARTMENT — G39296

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Glen Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Glen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Warshaw

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bessie Lipnick
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1881
8. AGE: Years 65 | Months | Days | If less than one day hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business: Retired

FATHER
12. Name: Solomon Warshaw
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sylvia
15. Birthplace: Russia

16 (a) Informant: Mr Ben Lipnick
(b) Address: 3502 Holmes Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/46 (month) (day) (year)
(c) Cemetery or crematory: Shaarei Tfiloh Cemetery
Location: Windsor Mill Road
18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-26 W. North ave
19 (a) (b) (Date rec'd by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946 at 7 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 F 1945 to 4/12 1946 and that I last saw him alive on 4/12 1946

Immediate cause of death: Coronary occlusion — Duration:
Due to: Atherosclerosis
Cardio Vascular disease
Due to:
Other Conditions: Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature: Daniel Wilson
Address: 5721 Gould Ave signed 4/13/46 M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G39297 G39297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Howard Rockler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-24-5204

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			min.

9. Birthplace Tuckova Latvia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Latvia

MOTHER
14. Maiden Name unknown
15. Birthplace Latvia

16 (a) Informant Marie Rockler
(b) Address 2807 W Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-46 (month) (day) (year)
(c) Cemetery or crematory Shrine Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1946 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1946 to 4-13 1946, and that I last saw h[im] alive on 4-13 1946

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to CORONARY THROMBOSIS with ulcerative myocarditis	9 days
Due to infarction	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: SEE ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott J. Wertzman M.D.
M. D.
Address Date signed 4-17-46

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

VS-180

639298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1378

639298 (over)
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Violet Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Friedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Anna Friedman
(b) Address 2610 Violet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-46 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) 4-14-1946 (Date filed by registrar) (b) Arlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1946, 2 25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pyelonephritis, bilateral

Due to Chronic Cystitis
Chronic Prostatitis

Other Conditions Generalized arteriosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-14-45 at 7 P. 15/12 M.
(b) Where did injury occur Lexington Rd. & Hilsdale Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Howard J. Weldin Medical Examiner. M.D.
Date signed 4-12-46

VS 151

G39299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G39299 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1673 W. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie Levin

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-3174

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business

FATHER
12. Name Abraham Asher Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Levin
15. Birthplace Russia

16 (a) Informant Mrs. Stanley Adler
(b) Address 1673 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-46 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1946, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion
Chronic myocardial degeneration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Thurman M.D. (Medical Examiner)
Date signed 4-12-46

VS 151

G39300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G39300 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Park View & Linden Ave
(c) ~~Hospital or institution~~: Alhambra Apts - 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Park View & Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon M. Levenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida Lee Rappeport

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER 12. Name

13. Birthplace Russia

MOTHER 14. Maiden Name

15. Birthplace Russia

16 (a) Informant Ida Rappaport

(b) Address Alhambra Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-46 (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew

Location Loch Raven Rd

18 (a) Funeral director Isaac Levin

(b) Address 1439 E. Balto. St

19 (a) 4-14-1946 (date received by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-46 19 , at 7:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-14 1946 to April-13 1946 and that I last saw him alive on April-13-1946

Immediate cause of death Coronary occlusion — Duration 8 hrs

Due to arterio-sclerosis & hypertension

Due to

Other Conditions Chronic lymphatic leukemia - 15yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herman Seidel M.D.

Address 2404 Eutaw Pl Date signed 4/14/46

942

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-20 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 36001 AND ENDING WITH 39300 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL